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Raising the Quality of Children's Lives

The Hospital and the Preschool Child

Black History in an Interracial Camp

Toward Reunion of Children and Parents

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children

AN INTERDISCIPLINARY JOURNAL FOR THE PROFESSIONS SERVING CHILDREN

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Two happy children in a day care program in a Brooklyn, N.Y., neighborhood house. That enjoyment of the present is itself a desirable goal for children that should not be overlooked in concentration on goals for their future is suggested by the emphasis put on the quality of children's lives by the new director of the Office of Child Development and chief of the Children's Bureau. (See pp. 166–70.)

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The director of the Office of Child Development and chief of the Children's Bureau presents his views on children and the role of OCD in their behalf

EDWARD F. ZIGLER

Since I accepted President Nixon's appointment as first director of the Office of Child Development and chief of the Children's Bureau, I have testified publicly on many occasions that I am committed to a national effort to raise the quality of life for children in this country. I realize, however, that "quality of life" has many connotations and so I would like now to explain my views more fully.

To my mind a commitment to the quality of children's lives inevitably involves concern with two intermingled aspects of children's experiences—their meaning for the child *today* and their meaning for the kind of person he will become in the *future*. It involves the alleviation of pain and the opening of opportunities for joy, satisfaction, learning, and adventure for the child's sake *now* as well as for nurturing all the child's potentials—physical, emotional, and intellectual—for becoming a socially competent, humane adult.

What can the Office of Child Development do to assure such experiences for children? I would be naive indeed if I did not recognize the difficulties presented by the complexity of children themselves, to say nothing of the complexity of this country, its heterogeneous population, its social structure, and its institutions, including of course, the Federal Government and the Office of Child Development itself.

Some people, including professionals in the child development field and members of the interested public, have expressed misgivings about the creation of the Office of Child Development. They have par-

A NATIONAL PRIORITY:

RAISING THE QUALITY OF CHILDREN'S LIVES

ticularly feared that the Children's Bureau, for so many years the major advocate in Government for children, would decrease in importance once it was placed in the new office, which also contains a major operating program, Project Head Start. My response to this concern is simply this: The Children's Bureau, in its advocacy function, will be even more important and influential under the present organization than it has been in the past. A number of new responsibilities will be given to the Children's Bureau to enhance its position as the nation's conscience in matters affecting children, and I pledge my wholehearted support for its efforts. I also believe that the creation of the Office of Child Development represents a firm commitment by this Administration to children and their families and that the entire range of Government programs for children will benefit as a result of this clear commitment.

When the President announced the establishment of the Office of Child Development in April 1969, he charged it with a special concern for children from birth to 5 years of age, in recognition of the crucial importance of these early years to the later development of the child.[1] The early years *are* critical in the development of the child, but so are the years that follow, for what happens to a child at any age may bolster or undo a good beginning. In broadening the Office of Child Development to include the Children's Bureau, with its traditional concern for the whole spectrum of childhood and adolescence and its legal obligation to investigate and report "upon all matters pertaining to the welfare of children and child life among all classes of our people,"[2] the Administration has recognized the continuous nature of human development and the importance of the quality of life for all children.

To carry out its responsibility to the nation's children, OCD has been given three specific charges:

1. To administer child development programs of high quality.

2. To coordinate Federal services for children and to provide leadership to States and localities for the coordination of all services for children.

3. To be an advocate and an innovator for children.

All three of these charges require a clear idea of what we want for children in this country and what we want them to become. If we want children to have satisfying lives as children and to grow into socially competent adults, we will have to retain a vision of the child as a whole, though constantly changing, human being. This means that we have to remain alert to the fact that anything we do to affect any aspect of the child will affect him in many other ways. If we lose our balance and concentrate on developing the intellect alone, we may devalue other qualities of individuals that are necessary for a humane community. In all our efforts we must keep the whole child in view.

How then will we proceed?

The realities of life—including the all too familiar shortages of manpower and money—will set limita-

tions on how much can be done and how fast, but I am certain that we will not be short of exciting ideas; and whatever we do, we will proceed with enough caution to assure that the goal of quality is not lost in a feverish effort to "get things done."

Child development programs

One major effort will be to see that the programs for which OCD has direct responsibility are programs of high quality. Thus far OCD has administrative responsibility only for one direct service program, Head Start, the health and child welfare services formerly administered by the Children's Bureau having been transferred to other parts of HEW. There is a distinct possibility, however, that OCD may be called on in the near future to administer a massive day care program.

Head Start. Head Start has recently been under attack largely because a study made by the Westinghouse Learning Institute found that school children did not retain IQ gains made during a Head Start preschool experience.[3] Among other oversights, this study failed to recognize that there is a great variability in native ability, emotional maturity, and degree of social deprivation experienced by the Head Start child; that there is variability in the quality of Head Start programs and in the length of time children attend them—some children in the study had attended only 2-month summer programs; and that there is great variability in the quality of schools children attend after participating in a Head Start program. (A child who has had a good preschool opportunity to learn may be completely turned off by an inferior school.)

To my mind, however, the major fault of the Westinghouse study was its failure to recognize the multiple purposes encompassed in Head Start's view of the whole child in the context of his family: to introduce children to continuing comprehensive health services,[4] to improve their nutrition, to raise their self-esteem, and to involve their parents in plans to improve the quality of their children's experiences. Nor has the study recognized the fringe benefits of Head Start. Elsewhere in this issue there is a discussion of a study[5] showing changes that have taken place in communities largely through the influence of Head Start programs. (See page 193).

To assume that Head Start's main purpose is to raise children's IQ's is to greatly misunderstand the program. To expect that as a result of a few months' experience any child's IQ could be raised and stay raised regardless of what happens to him afterward is to believe in a kind of educational magic that does not exist. To regard such a goal as the only desirable goal for children is to denigrate the value of all other goals of child development, including that most important of all ingredients of social competence—a healthy personality.

Elsewhere I have expressed my opinion of what I have called "the environmental mystique,"[6] the point of view that intelligence is trainable—that if you could just get the right experiences into children they would all be brilliant—a point of view that has grown out of the work of Hunt,[7,8] Bruner,[9] Deutsch[10] and others. These people are doing valuable research, but the popularization of their findings on cognitive development has resulted in expectations that children's ability to learn can be greatly enhanced through using technological gadgets and quick and easy techniques—expectations that can be destructive of both child and teacher when they fail to produce the desired effect. The recognition of the variability of native endowment has often been lost in the cognitive push, along with respect for qualities other than a high degree of measurable intelligence—patience, good humor, regard for others, to name a few.

As one of the planners of Head Start I am in perfect agreement with its goal of encouraging the development of every aspect of the child's endowment so that the uniqueness of his own personality can best be expressed. I am also in agreement with the program's emphasis on parental involvement in the achievement of this goal. This does not mean that I see no room for improvement in Head Start.

Today there are 1,800 local Head Start programs, operating in an autonomous fashion but receiving funds, guidelines, technical assistance, and personnel training through the Federal government or institutions working under contract with the Federal government. In the sense of what they are doing to and for children, the quality of these programs ranges, I suspect, from very good to bad, with the latter representing only a very small fraction of the total. We do not, however, have exact information on the quality of all Head Start programs.

OCD, therefore, will attempt to get more detailed information about the current status of Head Start programs by instituting a quality monitoring system. As a first step a contract will be made for a study of 150 programs in regard to their total efforts for children—health, nutritional, and educational—and their effect not just on what the child learns but also

on the child as a whole, his family, and the community. What we learn in this effort will be used in training members of OCD's regional staff in developing a continuous system of quality control.

Another effort, already underway, which will be effective in raising the quality of the curriculum aspects of Head Start programs, is a project of planned variations—a research effort to determine the effectiveness of various teaching methods as introduced in different Head Start centers.

Built-in methods of affecting the quality of Head Start programs through technical assistance and training opportunities will, of course, continue. One of Head Start's major achievements has been its production of a trained cadre of workers for preschool programs of any kind. Countless persons from the neighborhoods of Head Start centers, most of them parents of the children being served, have been trained to work in Head Start programs through its Regional Training Offices. Of these workers 7,500 have been taking college courses to prepare for career advancement.[11]

I am a firm believer in Head Start's policy of seeking talented people in the neighborhoods served to work creatively with children. But I do not believe that residence in a neighborhood in and of itself equips a person to work creatively with children. There are frustrated people in all strata of society who, because of their insensitivity to children's needs and responses, can do them great harm. If a Head Start program allows its enthusiasm for creating employment opportunities for neighborhood people to overshadow its responsibility to children, children may be endangered. While local control and parental involvement are sources of much of Head Start's vitality, they do not preclude accountability for the major charge: enhancing the quality of children's lives.

Day Care. At this writing OCD has no operating responsibility for day care, but it will certainly be involved in some way with the massive day care program envisioned in the pending Family Assistance bill,[12] if this should become law. To be ready for this eventuality, OCD has been designing proposed policies for administering such a program that would allow for a maximum of local flexibility and parental choice. It has also been working with the President's Science Advisory Council and the Office of Economic Opportunity in a project to develop principles and models of good day care practice for use by communities interested in establishing day care programs. To this end, a 2-week workshop of child development specialists and day care practitioners was held in Warrenton, Va., in July. The results of their work will be published soon.

Coordination of services

In regard to its charge to coordinate Federal programs for children, I see OCD's role as that of a guide rather than as a controlling authority.

There are already instruments for informational exchange and discussion among Federal agencies that might be strengthened to carry a coordinating function—the Interdepartmental Committee on Children and Youth, the Federal Panel on Early Childhood, and the Federal Regional 4–C Committees, all of which are staffed by OCD. Through the 4–C (Community Coordinated Child Care) program, OCD is stimulating coordinated planning among children's services in States and local communities.[13]

In addition, we are now planning the establishment of a secretariat within the Children's Bureau to map out all the Federal services affecting children. We can then spot overlapping areas, identify gaps in service, and so select targets for coordination and goals for our role as advocate for children.

Advocacy and innovation

The Children's Bureau during its 58 years of existence has served as an advocate for children, especially for children whom circumstances have made particularly vulnerable to developmental distortion. It has done this through setting standards for services of quality, providing technical assistance to the States in regard to the establishment and operation of services, drafting models for State legislation in areas affecting children, and recommending Federal legislation involving children's services. This type of effort will continue.

At present, for example, the Children's Bureau is mounting two related campaigns based on the belief that every child needs to grow up in the security of a family. Their purposes are (1) to swell the supply of foster families for children who, for a variety of reasons, need care away from their own parents; and (2) to increase the availability of prospective adoptive parents for hard-to-place children.

In addition we are planning to provide a channel within the Children's Bureau for fostering the Government's responsiveness to parents' concerns about their children. Called the Children's Concern Center,

this unit will serve as a focal point to which members of Congress, voluntary and professional organizations, Federal agencies, and parents and other interested individuals can turn for answers to questions on any subject within the whole range of child development. Besides gathering information for transmittal to the inquirers, the Children's Concern Center will provide OCD with a means of learning what people are concerned about that might be translated into programs for children and their families.

Creative advocacy implies innovation. OCD will be an innovator, sometimes by suggesting appropriate services to other Federal agencies, sometimes by directly initiating a program on a demonstration basis, sometimes by acting as the catalyst for a mix of agencies from which a jointly operated program can emerge.

At present we are engaged in exploring ways to develop a program that we hope will have salutary effects not only on the quality of life of both teenagers and young children today but also on the future quality of parenthood in this country. The purpose is to promote opportunities for teenagers to work with the young in either a tutorial or child care capacity and to teach them the basic information and skills for child care. A recent OCD-sponsored conference of child development specialists, representatives of other professions concerned with children, and teenagers already engaged in working with young children has provided some valuable suggestions for pursuing this objective. (See p. 197). It is my fervent belief that teenagers and young children have something to offer each other and that a purposeful association between them can redound to the benefit of both.

We are also going to set up a section within the Children's Bureau to call attention to the needs of especially vulnerable children—children of migrants, retarded children, Indian children, and others.

We plan too to back a solid investigation of the effects of television on children—the good effects as well as the bad. Television is an integral part of the lives of the vast majority of the nation's children from their very earliest years, and yet we have no clear knowledge of the effects of long-term television viewing on children's socialization and development.

The whole child

OCD, with its limited resources, cannot be all things to all children, but it can serve as a conduit for the best thinking about children in this country to reach policymakers and people who work with children. In this way it may help to increase the sensitivity of those who affect children to children's needs as whole human beings.

It seems to me that the goals laid down for Project Head Start at its inception are appropriate goals for all efforts for children or young people of any age. In brief, these goals are:

- Improving the child's physical health and abilities.
- Encouraging self-confidence, spontaneity, curiosity and self-discipline.
- Increasing the child's capacity to relate positively to others, while strengthening his family's ability to relate positively to him and to understand his problems.
- Developing in the child and his family a responsible attitude towards society and creating opportunities for people to work together to improve social conditions.
- Helping the child and his family to an increased sense of dignity and self-worth.

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[10] Deutsch, Martin, and associates: The disadvantaged child. Basic Books, New York, N.Y., 1967.

[11] Flynn, John: A boost toward career advancement: college training for Head Start workers. *Children,* March–April 1970.

[12] HR 16311, Family Assistance Act of 1970. Revised and resubmitted to the Committee on Finance by the Administration. June 1970.

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THE HOSPITAL AND THE PRESCHOOL CHILD

T. P. MILLAR

Nearly two decades ago the pediatric literature was filled with reports concerning the psychological damage hospitalization can do to a child. Recommendations to change the pattern of child care in hospitals were made, but rarely implemented.[1] Today concern over the risks of hospitalization for children's development is rising once again.[2]

In 1953, Prough [3] reported on 50 preschool and primary grade children who had been hospitalized for an average of 8 days. He found that 92 percent showed "significant disturbances in behavior not present prior to hospitalization." Nor were these simple, self-limited reactions. Three months later 15 percent of these children still showed signs of their difficulty.

There is little reason to believe that the psychological effects of hospitalization in children are any less today. Therefore it is pertinent to consider how such disturbances may be prevented, or, if that is not possible, how they can be so dealt with in the post-hospital period as to minimize their effect on the psychological health of the child.

What kinds of disturbances do children show after hospitalization? What is their meaning for the future well-being of the child?

"The worst part was when she first came home," the mother of a 4-year-old told me one day, her face a mirror of distress. "So fussy, and she wouldn't eat unless I fed her. She couldn't get to sleep, unless I stayed in with her. It was 3 months before she stopped calling out with bad dreams."

Another mother dealt with her distress about her little girl's post-hospital behavior by blaming the nurses. "She was all but trained before, but when she came home she was soiling and wetting again. I don't suppose they bothered to potty her. They just put her back in diapers because it's easier. I guess they're busy with all those sick kids."

A third mother was filled with self-recrimination about the effects of a hospital stay on her young son. "At first he kept saying, 'Why did you leave me there?' It's as though he blames me. Maybe I *should* have stayed with him. I could see I would just be in the way, but maybe I should have stayed anyway.

Now, 6 months later, he won't leave the yard to play. At first, I had to stand in the window where he could see me. If someone in a white coat, or even someone carrying a pair of scissors, comes near him, he starts screaming and carrying on."

But mothers voice their greatest concern about a child's hospital experience when they ask: "What has this done to his growing up?" And they may sadly add, "He was doing so nicely. Now he's . . . he's just not coping anymore."

Interference with growth

What indeed does hospitalization do to the child's process of growing up? An adult can take 6 months out of his life to recover from an overwhelming experience and come back to where he was before, but can a child? What happens to the normal psychological growth processes while the child's energies are so diverted?

The preschool years are those during which the psychological growth of the child is proceeding by giant steps. This is the period when the child is discovering and practicing new ways to cope with the world, laying the groundwork crucial to his later successful adaptation. At this busiest of times the child cannot divert his energies to dealing with an overwhelming emotional experience and still achieve this complex psychological growth at a normal rate. Therefore, ***even brief hospitalization carries with it significant psychological hazard, especially for the child under 4 years of age.***

Rooming in at the Children's Hospital, Washington, D.C., a mother helps keep her child's mind off the unpleasantness of hospital life through the comforting security of her presence.

Why is this so? What is the nature of the stress the child experiences? How does he react to that stress and what do his reactions mean? The answers to these questions hold the clues to rational prevention and alleviation of damaging reactions.

To begin with, stress *per se* is not the unmitigated villain. Some stress is essential to normal psychological growth: the right amount at the right time stimulates the maturation of the child. Indeed, the child who is protected from normal stress by indulgent or excessively protective parents will often remain adaptively immature.[4]

Whether a stress is overwhelming or conducive to growth depends upon the present adaptive capacity of the child. In many instances, hospitalizing the preschool child subjects him to a particular kind of stress, *separation* from his mother, for which he is psychologically unready. His limited adaptive capacity is then overwhelmed by the experience.

To understand this, it is necessary to look at the normal way in which a child psychologically separates from his mother. The achievement of such separation by the growing child is the end point of a gradual process, a process that cannot be abruptly accelerated.

The infant begins by experiencing the protective care of his mother as a kind of fusion. Step by step he becomes aware of his physical separateness, of his mother's independent comings and goings. Only much later does he understand, and concede, her independence from him. In this gradual way he comes to appreciate his separate individuality.

Each step in this process brings the child a wider perception of reality, and, largely because of his helplessness, a measure of anxiety. That anxiety, kept to tolerable proportions by his mother's protective presence, is ultimately mastered by learning to cope with reality. Thus, for the child today's crisis becomes tomorrow's exploit, and the concerns of yesterday come to seem like foolish apprehensions.

Hospitalizing the preschool child violates this process. The degree of separation involved is usually beyond the adaptive capacity of the child. As though this were not enough, the child is at the same time subjected to other stresses. He is likely to be in pain, which may well be the worst feeling he has ever known, and his mother, who usually takes away un-

pleasant feelings, is not there to help him. He is surrounded by strange people whose clothes are all alike, but whose faces are somehow different—people who stay a while and then go away. Sometimes they return, sometimes they do not. Some of them wear masks, like bad guys on TV. They smile, then do things that hurt. There are giant machines that tilt and whirr and descend on you. Things smell funny. Any hour of the day or night somewhere children are crying.

For the child under 4 years of age, the hospital is a strange and frightening world, and he is alone in it.

Protest, despair, denial

How does the child react to all this strangeness and stress? James Robertson, in his classic little book, "Young Children in Hospitals",* describes three stages of the child's reaction. With eloquent parsimony he calls these stages *protest*, *despair*, and *denial*.

The first reaction of the aggrieved child is protest. He cries, shakes his crib, throws himself about. He will have nothing to do with the nurses. He wants his mother back, and *now*. He listens carefully to each approaching step, until he knows it is not his mother returning; then he resumes his protest. Gradually, however, as his disappointments accumulate, his protest loses its intensity. He is beginning to despair.

Acknowledging his loss, he has begun to mourn. He withdraws, becomes inert and apathetic. When the nurses make overtures to him, he does not respond. His cry is intermittent, and its character has changed. It has become a monotonous, wailing lament.

Sometimes, when despair sets in, busy nurses, noting only that the child has stopped shaking his crib and screaming, say he is "settling in, becoming adjusted to the ward". They may welcome the respite. They do not always recognize the onset of hopelessness or realize that despair is burying itself within the child.

When the child's mother visits him, his behavior changes. He becomes angry and distressed. He clings to his mother, and when it comes time for her to leave, he protests again with all the vigor he once displayed. Because the mother's visits seem to make him more unhappy, the nurses sometimes feel it would be better if the mother did not come to the hospital.

Some children whose hospital stay is prolonged eventually pass from despair to denial. They regain interest in their surroundings, respond to the nurses, begin to smile again. When a mother visits, the child may seem barely to recognize her, and when she leaves he may not protest. It is as though this most crucial of relationships has lost all meaning for him. Sometimes, when the child leaves the hospital for home, he clings to the nurse and treats his mother as though she were the stranger.

When such a child returns home, the inner conflict and anxiety, temporarily managed, come to the surface once more. He becomes aggressive and reacts to the mother as one who abandoned him. He has nightmares and shows phobic reactions toward objects that remind him of the hospital. Until the child has worked through these feelings, he cannot resume his psychological growing up from the point at which he left off when he entered the hospital.

Many a mother, intuitively recognizing her child's needs for special handling at this time, may respond to the child's distress with sympathetic concern. Sometimes her concern undermines her judgment and she establishes a pattern of overprotectiveness, failing to recognize when protectiveness is inappropriate. In my experience as a child psychiatrist, I have seen a number of women with adaptively immature children whose infantilization began with the mother's reaction to the child's reaction to hospitalization.

Because the symptoms of emotional disturbance often do not appear until the child has returned home, hospital staff members are sometimes unaware of their frequency and magnitude. It is important therefore to reiterate: ***hospitalizing the preschool child exposes him to separation and other stresses that are frequently beyond his adaptive capacity, and may interfere with his subsequent psychological growth.***

Prevention and alleviation

What can be done then to prevent or minimize the psychological hazards of hospitalization for young children? Two approaches are necessary: (1) to *avoid* hospitalizing children whenever possible; and (2) to *redesign* hospital child care practices to reduce the stress of the child's hospital stay as much as possible.

For the child under 4, avoiding hospitalization is the preferred course and one that may be more possible than it may seem at first thought. Children are sometimes brought into hospitals to clarify diagnoses through observation and laboratory tests that might, with a little ingenuity and inconvenience, be man-

aged in the physician's office or in the hospital's outpatient clinic. The practice of some insurance plans of paying for tests when done on a hospitalized patient, but not for the same tests when done on an outpatient, may be a factor in promoting admissions of this kind.

In considering whether to hospitalize a child, the physician has a responsibility to weigh the advantages against the disadvantages. But like other experts in these days of specialization, the physician tends to focus his attention on his particular area of competence, the physical health of the child. Thus, he may fail to give proper weight to the possible psychological consequences of hospitalization—a major hazard for children under 4. The child's parents, of course, have to rely on the physician's judgments.

If parents and physicians were willing to make the effort not to hospitalize children, many sick children might be nursed effectively at home. Much hospital equipment is portable: beds, croup tents, intravenous stands. With a visiting nurse as a daily consultant, the mother may be able to care for the child herself. Homemaker services—if available—might be called in to assume some of the household burdens while the mother is so occupied. Expensive? Perhaps, but surely not more than the $50 to $75 a day it now costs to keep a child in a hospital. This assumes, of course, that these supporting services exist in the locality in sufficient quantity to be available when needed. In some areas they do not.

When hospitalization cannot be prevented, can the child's stay in the hospital be shortened? There is a tendency to keep the child one more day, "just to be sure," or over the weekend because "administration has gone home." If physicians and hospital staff members recognized the urgency of getting the child home as soon as is consistent with prudent care, they could, I am sure, reduce the length of hospital stay for many children.

For the child who must stay in a hospital for more than a day or two, steps should be taken to reduce the stress he undergoes while there. For the child under 4, this means minimizing the separation from his family.

The most effective way to do this is to admit the mother along with the child. There is nothing particularly new about this idea.[1, 5] Indeed, in less developed societies it is the rule,[6] and people view the western practice of separating the sick child from his mother as bordering on the barbarous.

The technique of such double admission, sometimes called rooming-in, involves the provision of a cot and living arrangements for the mother near her child, and encouraging her to participate in his care. While such an arrangement may or may not complicate *patient care*, there is considerable evidence that it improves *child care*.

Despite its demonstrated value,[5] rooming-in has not become popular among the staff and administrators of hospitals. Those who resist it argue that the mothers are more bother than help, that they are anxious about their children and find it hard to participate in their care. Failing to recognize a child's protest as a psychological necessity, the resisters point out that the children's ward is quieter when the mothers are not there. Even so, increased psychological risk to the child is too high a price to pay for peace on the ward.

The practice of allowing mothers liberal or unrestricted visiting is another useful way to reduce the impact of separation of the hospitalized child.[1] Such visits may upset the child, but when they do they are *uncovering* his distress, not *creating* it. Thus, they help the child discharge some of his accumulated tension. More important, perhaps, by reducing the degree of separation of mother and child, they provide the child with evidence that he has not been totally abandoned.

Although the practices of rooming-in and unrestricted visiting have proven of value in reducing children's reactions to hospitalization, it is my impression that such policies are uncommon in hospitals in this country outside of university settings.

The resistance of hospitals to instituting such measures arises in part from a failure to understand the situation. After all, it is said, entering a hospital is always a kind of disaster and some degree of emotional upset is probably inevitable. Because physicians and nurses see a lot of tragedy in families, they may lose sight of the significance of a traumatic experience to an individual child. Living as they do with the necessity of watching children die, they

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may, understandably, not be moved to action by the psychological problems of the briefly ill child. Moreover, such a child soon disappears from their sight. Unless the mother complains, physicians and nurses may easily assume that all became normal again as soon as the child went home.

For some or all of these reasons, children are not being protected from the psychological risks of hospitalization. Recently, however, a group has been formed that is reawakening concern over this problem. Called the American Association for Child Care in Hospitals, it grew out of a meeting of child development specialists held at the Boston Children's Hospital in 1965 and was formally organized the following year to include representatives of various professions concerned with the health and well-being of children.[2] Its goal is to advance family-centered pediatric hospital care.

Another aspect of this problem was illumined by Robert S. Mendelsohn, M.D., formerly director of the American Academy of Pediatrics' Consultation Service to Project Head Start, when he asked the compelling question: Could parents sue a hospital and doctor for psychological damage to the child?[7]

When the child goes home

Even when appropriate preventive measures are taken to lessen the psychological effects of hospitalization on children, the experience will prove overwhelming to some children. Disturbances will occur. What can the physician do to help the mother cope with these difficulties in a way that will restore the child to normal psychological growth?

When the child goes home, he is driven by two principal needs. The first is to discharge his accumulated affect, to desensitize his trauma. So, he complains, blames, fusses, demands, and expresses fear that his mother may abandon him again. The second need is to be "filled up" with the kind of closeness he once had with his mother. He needs to have a period of excessive maternal gratification to make up for the period of loss, to reestablish his normal degree of dependency on his mother and to restore his trust in her.

Intuitive mothers often recognize the child's need for additional closeness and try to meet it. Yet they wonder if they really ought to be feeding the child again, or allowing him to cling. Their uncertainty makes them anxious. Their anxiety sometimes misleads them. They may feed the child but scold him as they do so, which is neither "filling him up" nor

A cheerful visitor helps make lunch a happy affair for a group of children who are convalescing in a hospital ward.

getting him to assume his normal responsibilities again. Or their anxiety may lead them to blame the hospital nurses or themselves, which in no way improves their judgment with respect to dealing with the child.

The physician can inquire, listen, and advise, and an important benefit will be a reduction in the mother's anxiety. By talking to the physician about the behavior that worries her, and by learning from him that such symptoms are common after a child's visit to a hospital, the mother becomes more relaxed. With her anxiety relieved, her judgment about the child is restored, and the prospects of her anxiety being converted into the kind of excessive solicitude that leads to continued infantilization of her child are reduced.

The doctor says something like: "Don't worry if he's back to baby ways for a little while. Feed him, spend time with him, indulge him a little. In 10 days we'll start worrying about helping him grow up again." And if the child is keeping the mother awake, the physician can prescribe a little mild sedation for a few nights. Direct advice reassures, and the physician should not hesitate to dispense it.

Growing up again

The second phase of post-hospital care is concerned with getting the child back to the business of growing up.

Most of the child's symptoms are directly traceable to a pervasive separation anxiety. He clings to his

mother and will not let her out of his sight. He cannot go to sleep if she is not there or out to play unless she remains in sight by the window. Clearly, he is afraid that he will be abandoned again.

Separation anxiety may be *alleviated* by not separating, but so handled it does not become more manageable in the future. Separation anxiety is *mastered* by experiences of successful separation—that is, experiences of separation that are long enough to produce a degree of anxiety in the child, but not so long as to overwhelm the child's present adaptive capacity.

Therefore, once the child is reasonably "filled up" again with maternal protectiveness, the mother, if she understands what is required, begins to impose brief separations upon him. She makes a point of going out for half an hour, perhaps in the early evening when her husband can babysit. The child protests her going and is tearful on her return. She goes again, and again the child protests. On the third occasion, however, his protests are less vehement. This time she stays away a little longer or she may leave him with a person less familiar to him—a neighbor perhaps. Thus, gradually increasing her expectations, she leads the child back to the point of adaptability he had reached before he went to the hospital.

Through this purposeful imposition of separation, the mother is engaging the child in a process of desensitization and relearning. Each time she leaves and returns, the child fears he is going to be abandoned but discovers he is not. When the mother returns he learns (through experience, the principal way very young children learn) that abandonment and overwhelming anxiety are not inevitable consequences of separation. By mastering small doses of separation, he stretches his capacity for functioning independently. Gradually his lost trust is restored.

The physician can help the mother with this process. He does so primarily by supporting her, by dissipating her anxiety, by reassuring her, by letting her bolster her uncertain efforts with his authority, and by helping her decide the specific moves she will make. He continues to support her until a measure of success convinces her she is on the right track.

Without such help, there is danger that the mother will gravitate into a cycle of action and reaction that impedes the child's growth. For example, the mother may continue to defer to the child's apprehensions and meet his infantile expectations until, anxious about his persistent immaturity and wearied by his demands, she loses patience and suddenly explodes with excessive expectations. The child cannot meet these expectations, and he reacts with tears and further regression. Filled with remorse, the mother "makes it up to him" by renewed indulgence. She is back where she started and the cycle begins again.

The outcome of such a cycle can be a serious delay in the adaptive maturation of the child. In a few years there may be such a noticeable discrepency between the child's capacity and the expectations of his world that psychiatric help is needed to restore a growth-inducing mother-child relationship.

It would be better, of course, if children never had to enter a hospital, but they do, and the reality must be accepted and coped with. Patterns of in-hospital care need reappraising *now* to preserve the emotional as well as the physical health of the child. Even so, prevention remains the superior remedy.

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Even if science shows us the way to feed billions more—as indeed it may—we still would not have mastered the population problem. The full solution depends also on society's ability to meet man's higher, nonmaterial needs, to offer every child an opportunity to achieve in life more than mere existence—a chance to *live* as well as to survive . . . .

John D. Rockefeller, 3d: "Toward the Enrichment of Life" In* "Family-Planning Programs: an international survey," *Basic Books, New York, N.Y. 1969.

THE EFFECT OF BLACK HISTORY ON AN INTERRACIAL GROUP OF CHILDREN

BELLE LIKOVER

As racial tensions continue to escalate and the schism between black and white deepens, professional workers who serve young children have become acutely aware of their responsibility for dealing with racial prejudice. Teachers, social workers, day care workers, nursery school personnel, and religious leaders are daily grappling with the problem of how to become more effective in developing respect and understanding between persons of different races.

Most professional people have long been familiar with the axiom that the transmission of prejudice can best be blocked in a young child whose attitudes and behavior are still flexible. However, the field of human relations has produced little research on how to overcome prejudice.

What has been lacking in the American consciousness at all age levels is the history of the black people and the effect on them of historical and economic events. Schools have largely neglected the degradation and brutality of slavery and subsequent exploitation of blacks and also the achievements of blacks and their contributions to the productivity, growth, and thought of this country. With few exceptions, textbooks have ignored blacks completely or presented only racist stereotypes.

Currently the black community is pushing for courses in black history in the public schools to consolidate the feelings of black pride, dignity, identity, and solidarity. Knowledge of black history is equally important in the white community; overcoming white racism requires a factual basis for understanding why opportunity has been denied to the blacks.

This was our rationale at the Jewish Community Center of Cleveland when in 1969 we undertook a demonstration study of the effect of the introduction of black history on behavior of children in an interracial group at Playland, a summer day camp operated by the agency for children who have completed kindergarten or first grade. Herman A. Eigen, executive director of the Jewish Community Center, encouraged us to do the study, which was made possible by a grant from the Frances W. and H. Jack Lang Foundation.

Marvin Rosenberg of the School of Applied Social Sciences at Case Western Reserve University gave us invaluable assistance in designing the study. We relied heavily on a theoretical proposition that there is an integral connection between cognitive and affective domains in human development.[1, 2] The cognitive domain deals with knowledge and information, the affective domain with feelings and emotions. The theory suggests that all behavior has both cognitive and affective components, which cannot be separated.

Because of their essential interdependence, both the cognitive and the affective components of human relations programs must have equal emphasis if changes in attitudes and behavior are to be achieved. However, most attempts to improve race relations have dealt almost exclusively with affective domain. Also, much of the material developed for children

in this field emphasizes the biological and aspirational similarities of all races and deemphasizes the differences between the races.

We therefore included a cognitive structure in our program, based on historical facts rather than myths, stereotypes, or wishful thinking. We assumed that if both the affective and cognitive components of the program received equal emphasis, we would be changing attitudes and that these changes could be observed in the interaction between black children and white children.

Basically we were concerned with observing behavior rather than measuring attitudes. We looked at the behavior of white children and black children toward each other as the measure of understanding and acceptance.

The setting

The study was carried on within the regular framework of the Playland program. We knew from Mary Ellen Goodman's classic work, "Race Awareness in Young Children," [3] that racially related value systems and the onset of bigotry are to be found in children as young as 4 years. Thus the 6- and 7-year-old children in our camp were old enough to be aware of race but still young enough to be influenced by new information and experiences.

The children who attended Playland came from the population served by the agency—predominately middle-class, white, Jewish, suburban families—and generally included only a few black children. In 1969, however, we actively sought children from black families living in the communities adjacent to the center. We explained to the black parents that one of the goals of Playland was to help children accept racial differences and we gave seven partial scholarships to increase the number of black children in attendance. In this way the day camp enrolled enough black children whose socioeconomic status was comparable to that of the white children for a valid study.

Neither the children, black or white—nor their families—were aware of being in an experimental program. Such information was carefully concealed to avoid the "Hawthorne effect," [4] a distortion of findings that occurs when subjects, knowing that they are part of an experiment, give answers that they think are expected instead of expressing their own convictions.

Since I was director of both the day camp and the research project, the study group had to be limited to a size that would permit me to carry out my responsibilities in both capacities. The Playland program had separate groups for girls and boys, and we decided to confine the study to two matched groups of girls—13 in each group. The study was conducted over a period of 4 weeks, during which the children attended Playland 4 hours a day for 5 days a week.

In selecting the experimental and control groups, intake material on all the girls registered in the program was carefully examined. Children from broken homes and children with physical or emotional handicaps were excluded to make sure that results would not be influenced by differences in personality or individual frustrations.

We selected 26 girls—16 white and 10 black—for the study. They were assigned either to the experimental group or to the control group by a random assignment stratified for race and school grade level. The racial composition of the groups was identical; in each group of 13 girls, five were black and eight were white. The groups were also identical in the girls' school levels; in each group eight girls had completed kindergarten and five had completed the first grade. The number of whites and blacks who had completed kindergarten or the first grade were identical in both groups.

A college student with some experience in working with children was selected as counselor for each group. These girls were given an orientation about the purpose and design of the study to insure their understanding of the difference in programing for the two groups. High school girls who volunteered as junior counselors were given the same orientation and their roles were clearly defined. All counselors received consistent supervision from the camp director.

The only additional staff member hired for the study was a nonparticipant observer. Combined with experience as a nursery school teacher, day care center director, and Job Corps counselor, she had

Belle Likover conducted the demonstration study she describes in this article in 1969 while program director of Playland summer day camp operated by the Cleveland Jewish Community Center. During her 8 years with the center, she has served as group worker in the children's division and is currently supervisor of the young adult program. Mrs. Likover holds a master's degree in social science administration from Case Western Reserve University.

sensitivity, insight into children's behavior, and interviewing skills. She divided her time between the experimental and control groups in order to observe patterns of interaction and behavior among the girls. Introduced to the campers and parents as the assistant to the program director, she was completely accepted as a staff member. Although she would chat informally with the children, she functioned strictly as an observer: she did not in any way interfere with or direct any program or activity and she did not write her observations in front of the children.

Program

Playland offered the usual range of day camp activities—games, music, dancing, creative arts, swimming, and the like. The program during the first week was the same for all the children. The first week also served as a pretest period for the initial observation of the behavior of all the girls in the control and experimental groups toward girls of another race.

The girls in the two study groups were separated as completely as possible in the camp settings; except for swimming, they did not engage in joint activities.

One of the goals of the Jewish Community Center—the transmission of Jewish culture, history, and ethical values—was used to set the stage for the teaching of black history and to reinforce the basic concepts of tolerance. During the first week of camp the program theme was Jewish holidays around the year. Each group selected a different holiday to explore. The experimental group chose Passover, from which the girls learned of the oppression and slavery of the Jews in the Biblical period and of the concepts of justice and equality of all men. With this background the girls were later able to compare and contrast the slavery of the Jews with the slavery of blacks in this country. It helped them translate the concept of justice from history to today's world.

Black history was introduced to the girls in the experimental group at the beginning of the second week through many program forms, including stories, dance, song, art, and discussion. The counselor, with help from the camp director, translated the historical material to a level appropriate for 6- and 7-year-old girls. Using the camp's general theme for the second week—independence and freedom—the experimental group concentrated its attention on the struggle of blacks for freedom.

The study began with the period of slavery and continued to the present. One of the counselors described one day's events:

> **With the aid of a puppet who represented Thomas Smith, a Negro slave, I told the "real and true" story to the girls of the black people's struggle for freedom in the U.S.A. from the time of the first shipment of Africans to southern shores to the present, concentrating on the years of slavery and hardship. The girls reacted most violently to the account of certain physical and emotional hardships that the slaves suffered—the hot sun, dirty small cramped living conditions, the separation of father from mother and children. Terry (white) asked incredulously, "You mean children were taken away from their mothers?"**
>
> **Kelly (also white) asked, "And they weren't allowed to marry who they wanted to?"**
>
> **The nonverbal expressions of shock on the part of the white girls were unmistakable.**
>
> **I emphasized the fact that in 1776 "not everyone was really free" and just what this meant. I also mentioned that until a few years ago blacks and whites were not allowed to eat in the same restaurants or use the same bathrooms in the South—a fact which both surprised and shocked the girls.**
>
> **Throughout the discussion most of the black girls were quiet and seemed almost uncomfortable, with the exception of Anne, who was quietly absorbed and who really bloomed. . . .**
>
> **Nancy (black) had quite a lot to tell about her next-door neighbor who tried to buy a house and couldn't because she was black. Terry said with feeling, "Just because you have different color skin doesn't mean you are different."**

Later each girl in the experimental group made a slave puppet. The group wrote a puppet show that included among other songs, "We Shall Overcome." In developing the show, the girls discussed the meaning of the song with their counselor.

During the third week of camp the girls explored the contributions that blacks have made to American society under the program theme, great Americans. Biographical material about Negro heroes was presented. One of the heroes was Martin Luther King, Jr.—a man most of the girls already knew about. Discussion of his life gave the group an opportunity to reexamine the kind of discrimination he fought against as well as his philosophy of cooperation between black and white.

The counselor chose another hero, John Henry, to illustrate the contribution of black labor to the building of America. She later reported:

> **I used a beautifully illustrated story book about John Henry that was completely captivating.[5] Anne (black) said, "He was a very brave man."**
>
> **Linda (black) told a story about her grandfather who had worked very hard and died of a stroke. Ellie (white) reminded**

us that whereas John Henry had died, Martin Luther King had been killed. "Assassinated," said Linda.

The girls learned the song "John Henry." Nancy (black) told the girls which words to stress and, without any coaching from me, the girls then sang the song with a great deal of feeling.

During the first week the control group studied Purim, another Jewish holiday with an emphasis on freedom. However, instead of following it up with the material from Negro history, this group's next unit theme was freedom of speech. In the third week the control group learned about Johnny Appleseed and other farmers as American heroes.

During the second and third weeks in the control group, discussions of the girls' feelings about race were stimulated by the introduction of two picture books, "In Henry's Backyard" [6] and "Your Skin and Mine." [7] Both books present classic anthropological concepts about race in a form that elementary school children understand. This material was also used in the experimental group, but none of the program material developed for the experimental group was used in the control group.

The effects

We used three measurements to determine the effectiveness of the experimental program:

1. ***An interaction scale.*** Previous experience with interracial groups from a middle-class socioeconomic level taught us not to expect open hostility. Such children usually show their prejudice through avoidance—reluctance to sit next to a child of another race, to select her as a partner, or to initiate a conversation with her.

Counselors and junior counselors were instructed never to direct children toward partners. Thus each child was allowed to make her own selection of friends at all times. Counselors deliberately provided many opportunities for observing the children's preferences by asking the girls to pair off as they moved from one part of the building to another and as they changed activities.

At the end of the first and fourth weeks of camp, ratings were made for each child on a five-point racial interaction scale. (See col. 2.) The counselors and the nonparticipant observer rated each child separately.

2. ***Daily process records*** kept by both the counselors and the nonparticipant observer. These records presented a rich story of each child's behavior toward the children of the opposite race.

3. ***Concepts that the children expressed at home.*** At the conclusion of the 4 weeks the mothers of all the girls from both the experimental and control groups were interviewed by either the nonparticipant observer or the camp director. The mothers were asked such questions as: What did your child discuss at home about Playland? What was her reaction to her experience? If these open-ended questions did not evoke a relevant response, the mother was asked if her daughter mentioned anything about race. At the conclusion of the interview, the mother was informed of the experiment and asked her reaction to it.

At the end of the first week of camp, a distinct color line was obvious in both the experimental and the control groups. With few exceptions the black children stayed together. They reached out to the counselors rather than to the white girls, intuitively feeling that this was "safe" for them. Although none of the white girls showed any hostility, few of them made any effort to reach out to the black girls.

There was no tension between the whites and the blacks in either group. All the children worked on common projects without friction. However, interaction between the races was minimal; basically an ignore-but-accept pattern developed.

After black history was introduced in the experimental group, a new pattern of interaction began to

RACIAL INTERACTION SCALE

Positive behavior toward opposite race	5	4	3	2	1
Sits next to					
Picks for partner					
Engages in conversation with					
Shares materials with					
Holds hands with					

Scoring: 5—repeatedly, 4—frequently, 3—sometimes, 2—rarely, 1—never.

This scale was originally planned to measure both positive and negative aspects of the children's behavior but the negative measures were discarded because of the absence of overt hostility.

evolve. The black girls no longer relied on the counselors for support but began confidently to reach out to the white girls. The white girls also made overtures in an easy natural way and developed friendships with the blacks.

The following illustrative vignettes are from the reports of the counselors and the nonparticipant observer.

There was a definite show of affection between Lollie (black) and Betty (white) . . . None of the black children were forced by exclusion to be partners with one another . . . Kate (black) once again asked a white girl to be her partner . . . Linda (black) walked down to swimming with her arms comfortably thrown over Kelly's (white) and Ellie's (white) shoulders.

In the locker room Terry (white) for the first time picked Anne (black) for a partner and told her that she was pretty and cute—quite a change from Terry's reluctance to refer to Anne by name during the first week . . . Agnes (white) and Linda (black) argued over who would be Nancy's (black) partner . . . Nancy looked up and said with great joy, "They both love me!" She settled it by counting out.

Ellie asked Anne very seriously, "Does it bother you when we talk about Negroes?" Anne answered, "It's all right. It doesn't bother me at all. I don't mind a bit."

As this pattern of easy atmosphere and mutual respect developed in the experimental group, the pattern in the control group changed little. Except for one black girl who consistently sought out the white girls, the black girls tended to cluster together and continued to look to the counselor and junior counselor for security. Although there was no open rejection and all girls participated in activities, friendships developed mainly between white and white, and black and black. For the most part only superficial relationships were formed between black and white.

The difference in the two groups was corroborated by the staff members' ratings of the girls on the racial interaction scale. (See p. 180.) The overall ratings by the counselors and the nonparticipant observer showed basically the same picture, with some minor variations. The counselors showed slightly higher ratings than the observer at the end of the first week, however. This may be explained by the fact that the observer, who divided her time between the two groups, did not see as many instances of interaction as the counselors.

A racial interaction index (see p. 182) was obtained for each group by averaging the ratings of all the items on the interaction scale for all the girls in the group. This index showed that interaction had increased greatly in the experimental group after 4 weeks. Furthermore, examination of the individual scores of the girls showed that everyone in the experimental group increased her rate of interaction substantially. In the control group the individual increases in interaction were minimal.

Interviews with mothers

Perhaps the most dramatic evidence of the change in behavior in the experimental group was obtained through interviews with mothers, who reported the kind of information about race that the girls had brought home from Playland. At the end of the interview, each mother was asked not to discuss the purpose of the interview with anyone until all interviews were completed. In all cases but one, we believe that our request was honored and that mothers were not primed for our questions by other mothers.

All of the black girls in the experimental group had repeated at home the black history they had learned at day camp and had discussed the stories with members of their families. Such reactions could, of course, be expected. More significant perhaps was the poignant appreciation expressed by some of the mothers for the self-confidence and self-respect their children developed.

Mrs. M. said that Nancy came to camp aware that she was different. This child had experienced many fears and hurts at school because of her color. Her mother said that before the end of Nancy's camp experience, these fears began to disappear. Even during camp, she came home relaxed and at ease. One day she announced, "I am special." When her mother asked why, Nancy said, "Because I'm black."

Of the eight white children in experimental group, six told their families the stories of slavery, discrimination, Martin Luther King, or John Henry. Most of the girls gave their impressions with great clarity and feeling. They shared their anguish over the effect of discrimination in various ways.

One child said, "Do you know that Negroes at one time were forced to sit at the back of the bus?" . . . Several girls related their sadness about the treatment of slaves, especially the splitting up of families . . . When Ellie said to her mother: "I wonder how Anne feels when we talk about Negro people," her mother suggested that she ask Anne . . .

Elaine's mother asked her, "What's different about your Negro friends at Playland?" Elaine answered, "There is nothing different about them, they're the same." Elaine explained to her mother the difference between the Negro slaves in America

and the Jewish slaves in Egypt . . . Betty told her mother that Negroes still do not have their freedom.

Two white girls from the experimental group did not mention at home what they had learned at Playland regarding race, although both girls seemed to have understood the stories and both had made friends with black girls at day camp. For one of these girls, the lack of discussion may have been related to the general lack of communication in her home. The family of the other white girl openly expressed racial prejudice.

The interviews with the mothers of the girls in the control group told a substantially different story. Of the five black girls, four discussed some of the anthropological information at home. They were impressed by the story "In Henry's Backyard."[6] However, none of the white girls was sufficiently moved by this story to repeat it at home. Three girls made no mention of race, and their parents were unaware that any black children had been included in the camp program. Five of the white girls made derogatory remarks about blacks.

During the interviews parents of girls in both experimental and control groups made statements showing racial prejudice in about the same frequency. Similarly mothers in both groups made about the same number of favorable statements about the project. Therefore the differences in the attitudes of the children between the groups could not be attributed to differences in home atmosphere. A number of the white mothers from the control group expressed regret that their daughters had not participated in the experimental program.

Conclusions

The evidence indicates that the introduction of black history in the experimental group made a substantial difference in the interaction between the black girls and the white girls. We believe that paying equal attention to the emotional and cognitive components in our program led to a change in the girls' behavior patterns.

Certainly, a great deal more research is needed: the hypothesis has to be tested in different settings. Is this method applicable in a more formal setting such as a school that has larger classes and is multiethnic in composition? How could it be applied to other socioeconomic groups, other age groups, and other settings where there is evidence of open hostility? Can it be used in coeducational groups?

RACIAL INTERACTION INDEX

Group and rater	1st week	4th week
Experimental group:		
Counselor.....	2.45	4.41
Nonparticipant observer...	1.88	4.58
Control group:		
Counselor.....	2.43	2.75
Nonparticipant observer..	1.80	3.00

The increased interaction between the black girls and the white girls is expressed in this index, in which each figure represents an average of the ratings for all 13 girls in each group on all items in the racial interaction scale (see p. 180).

Some steps are already being taken to find answers to these questions. The study is currently being used by the Cleveland Heights-University Heights, Ohio, school system in curriculum planning and in-service training.

Our study was an attempt on a minimal budget to apply scientific methods to an existing program. Although the experiment was small in scope, the methods used can be replicated and adapted to other settings, age groups, ethnic groups, and socioeconomic groups. The information derived can immediately be translated into practice. The positive results may spur others on to report on their experiences in dealing with the vital issue of how to eliminate prejudice.

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REUNITING CHILDREN and PARENTS through casework and group work

HANNI B. EDINGER

In 1968 St. Christopher's School in Westchester County, New York, undertook an experimental program of intensive work with a group of parents of children in foster care. The purpose was to explore whether a combination of individual casework and group work might lead to improved parent-child relationships and speed the return of the children to their families. If after a year's trial the effort proved effective, then the agency expected to incorporate this type of service into its regular program. The costs of the experiment were met through a private gift to the agency and a grant from the Federation of Protestant Welfare Agencies.

St. Christopher's School is a voluntary, nonprofit, interracial, and nonsectarian agency that places and serves emotionally disturbed and neglected children in both institutional and foster family care. The children it serves come from New York City and surrounding counties.

Until the Parent Group Project was begun, the agency had relied almost exclusively on individual casework with children as its method of treatment. Because of insufficient funds and staff time, the staff was not seeing the parents on any regular basis. Moreover, the caseworkers frequently overidentified with the children, a tendency among staff members in child-caring agencies that makes parents feel isolated and rejected.

The Parent Group Project got underway at the beginning of 1968 and ended in March 1969 when funds for the experimental program were exhausted. It provided a selected group of parents with casework service through biweekly visits from a caseworker to their homes and with biweekly child-focused group discussions conducted by a psychiatrist.

Family casework agencies have for several years been providing group therapy to some of their clients "not primarily because it may save time or money or enable an agency to reach more people, but because it represents a treatment approach that has unique advantages for certain clients."[1] Some residential centers for children have also been working with groups of parents of children in their care, but reports of these efforts are few.[1-4] Therefore, it seems important to report the experience at the St. Christopher's School.

I served as the parent group caseworker for the duration of the project. My responsibilities included giving direct casework service to the individual parents; providing liaison between the project and the children's caseworkers; being the recorder and a participant observer at the group meetings; and making

periodic reports to the agency's board and staff on the progress of the project. The psychiatrist, Dr. Harvey Rosenblatt, led the group meetings and conferred with me for an hour each week. The caseworkers for the children, both in the institutional and the foster family home departments, helped select the parents for the project. They were kept informed of every step in the project's planning and progress through informal consultations with me and through meetings of all staff members connected with the project.

Selection of participants

In selecting potential participants, the caseworkers were asked to use the following criteria:

1. Parents whose involvement in the group could be expected to result in the child's returning home sooner than otherwise.

2. Parents in intact families who were not receiving public assistance.

3. Parents with children who were functioning moderately well at home and in the community.

4. Parents who had shown some ambivalence about placing their child away from home and had maintained regular contact with the child.

5. Parents who asked to have their child returned to them although the child had been removed from home by a court order.

Parents who were psychotic, had psychopathic personalities (drug addicts, criminal records, alcoholics), or were chronically ill were ruled out, as the chances of returning their child home seemed remote.

These criteria and restrictions were established to maximize the chances of the project's success. Some compromises had to be made, however. For instance, it proved to be impossible to find enough intact, self-supporting families to form a group of the desired size. Therefore, some divorced and unwed mothers, including two recipients of public assistance, were included. Geographic considerations also had to be taken into account, for although the children in care came from the entire New York City metropolitan area, the parents in the group project had to be willing and able to attend meetings at the agency's Manhattan office.

Eleven parents were originally selected for the project. The agency's director sent them letters of invitation to a new service "to provide extra time to discuss problems and plans in connection with the placement of your children." All but one of these parents accepted the invitation. The parent group caseworker then interviewed them either at their homes or in the agency's Manhattan office. The purposes of these interviews were:

1. To elicit information on—

- Their attitude toward the agency.
- Whether they felt there had been a change for better or worse in the way their child related to them since his placement away from home.
- Whether they could express their feelings about their children in a group of parents.

2. To explain the agency's reasons for establishing the project, what it would include, its experimental nature, and why they had been invited to participate. The parents were told that—

- The agency expected the parents' exchange of information and experiences in the group discussions to help the staff as well as the parents learn how to deal with their children's problems.
- Casework treatment would be offered as part of the project.
- They had been selected as persons who might like to participate in the learning experience offered and who might help the agency decide whether this type of service should become a part of the agency's regular program.

3. To find out what day and time would be most convenient for the group meetings.

The group

Seven of the ten parents interviewed actually became participants in the group, and six of these remained with it until the end of the project. Three additional parents joined the group after the project got underway. Thus the group had ten members in all; six attended the meetings fairly regularly.

The participants ranged in age from the late twenties to the middle fifties. They included five Caucasians, four Negroes, and one Puerto Rican. Although the project took place during a period of increasing polarization of the races and racial problems were discussed at the meetings, the group showed no signs of racial antagonism.

Hanni B. Edinger has been employed during the past year as a caseworker and parent group worker at the Clear View School of Westchester, Dobbs Ferry, N.Y. Previously she spent a year at the St. Christopher School in Dobbs Ferry, working on the project described here. With a master's degree from the George Warren Brown School of Social Work, Washington University, St. Louis, Mo., she has also worked as a school social worker in St. Louis.

We had hoped to involve fathers as well as mothers in the group, but because the meetings were held at 4 p.m. on weekdays, only one father attended more than a few meetings and he eventually dropped out because of a conflict with his work schedule. We found it impossible to set another meeting time because some of the mothers were afraid to go out at night and Saturday meetings were ruled out because of the psychiatrist's commitments.

Twenty-two group meetings, lasting an hour and a half each, were held from March 1968 to March 1969, with an average attendance of five participants. About the same number of casework interviews were held with each parent. To demonstrate the agency's wish to keep the parents involved, the time and place of the casework interviews were set at the parents' convenience: some were conducted in the parent's home, some near his (or her) place of employment during the lunch hour; some at the agency's Manhattan office after working hours.

The psychiatrist who led the group discussions let the structure of the meetings grow out of the parents' expectations, needs, and the kind of interaction that occurred. He imposed only one limitation—that the focus be kept on the child and his relationship to his parents.

Within this focus two patterns seemed to serve the purposes of the group best during the course of the year. In terms suggested by Scheidlinger [4] in his classification of attempts at influences that are not strictly in the clinical range of group psychotherapy, these patterns were:

The cognitive-informational focus—attention to the teaching of new information and the imparting of new attitudes.

During the early meetings the parents asked for all kinds of information. The staff members were astonished to find that parents whose children had been in the agency's care for several years knew little or nothing about the different services the agency offered or about its mode of operation. Parents whose children were in residential treatment were unaware of the existence of the foster care department and, conversely, those who had dealt only with foster home workers had no idea that the agency operated a residential treatment center.

After they learned about the agency's functions, parents began to ask questions concerning their children's symptoms and treatment: what is play therapy? what causes eneuresis? what is separation anxiety? why does my boy stutter? what does the institution do about homosexual activities?

This focus on information helped to relieve some of the parents' feelings of guilt for through it they learned that they could not be blamed for all that went wrong in their relationship with their children.

The relationship-experiential focus—the provision of an atmosphere conducive to the creation of a cohesive group that enables individuals to share their problems, dispel a sense of isolation, and receive emotional support.

This focus was probably of greater value to the parents than the first. It also brought repercussions on agency policy and practices.

The parents attested to its value for them in both the group meetings and the casework interviews. They told of how talking to others who had problems similar to their own had helped them overcome feelings of being alone with their problems and of having lost control of their children, so that they had become able to mobilize themselves into activity in their children's behalf.

The agency learned some things too. For example, one mother whose son was in residential care said, "I can't even buy him a pair of shoes anymore." All of the parents said that they felt intimidated by the professional workers who had taken over their parental functions but that they had not dared to question agency decisions. All seemed to have a nagging sense of having been labeled "bad" parents.

As the parents gained self-esteem, they began to challenge some agency decisions made for their children, especially those relating to visiting, telephoning, and letter writing between parents and child. They reproached the agency for not keeping them informed of their children's progress. They also supported each other in complaining about the children's caseworker, foster parents, or cottage houseparents. Because of the close working together of the parent group caseworker and the children's caseworkers,

such frank discussions brought some changes in the agency's policy in regard to specific children and an eventual realization on the children's part that their parents could intervene in their behalf. For example, opportunities to make regular visits home were offered one child who had not been home for a year and a half because his mother had been afraid to ask his caseworker to allow him to visit her and the caseworker had been waiting for the mother to take the initiative. Similarly, arrangements were made for other parents to receive copies of their children's report cards, to telephone their children regularly, and to see them often.

The discussions brought to light some facts previously unknown to the agency staff about the way two children were being treated by their foster parents. As a result, the children were moved to more suitable foster homes.

The combined methods

In the views of parents and staff alike, the combination of casework services with a group experience enhanced the therapeutic value of the program. The parents' caseworker found that one parent's open discussion of his problem in the group would often stimulate another parent to unburden himself of a similar problem in the privacy of the casework interview. Conversely, the group meetings often became more productive for everyone after the caseworker encouraged a parent to share a problem with the group that the parent had revealed in a casework interview. Feelings of guilt were alleviated when secrets came to the surface. For example:

Miss M, an unmarried mother whose son had been in the agency's care for 5 years following treatment in a psychiatric hospital, first told the caseworker and later the group that she had resumed living with the boy's father but had concealed this fact from the boy, who did not know that the man was his father. After working through some of her ambivalent feelings about this relationship in the casework and group discussions, Miss M decided to tell her son who his father was. A helpful father-son relationship grew out of this revelation. Moreover, with Miss M's approval the father began to participate in her casework interviews and also in the parents' group discussions.

Mr. B's son had come into the agency's care because of chronic truancy. A self-made man who had high expectations of his children, Mr. B was troubled because his son "acted like a stranger" when he came home. Through the casework interviews Mr. B gained some understanding about the underlying cause of his son's behavior. Through the group discussions he learned to scale down his demands on his son and to recognize the boy's tentative attempts toward rapprochement with him. Eventually the boy, who at first had not been eager to go home for visits, requested that he be allowed to spend the summer at home.

Because some parents continued in the group after their children were returned to them, others had a chance to learn about the problems that can arise after children return home following a long separation from their parents. Casework services, both to the child and the parents, were also continued after a child's return home.

Miss B, who drank heavily, had had her three children removed from her home because of neglect. The prognosis for a successful reunion of this family had been considered poor. However, the children's caseworker decided that to include Miss B in the parents' group might be worth a try. Through the experience, Miss B gained so rapidly in self-esteem that she demanded the return of her children. After the family was reunited, Miss B remained in the group and participated actively in its discussions, telling, often humorously, of her trials and tribulations, and asking for the group's advice. Six months after her children returned home, she and the children were obviously doing well.

Assessment

When the Parent Group Project came to an end, positive changes could be reported for all participants and their children. Of the ten parents involved at one time or another, three had their children at home, and four parents were working out arrangements for their children's return within a few months. The mother of two boys expected one son home soon but no definite date had been set. Improvement in parent-child relationships was apparent in the other two families, although they were not yet ready for reunion.

One cannot say for sure whether these results might have occurred without the intervention of the parents' group. However, the responses of the children's caseworkers to a questionnaire suggest that the program was effective. These eight workers responded to the following questions:

1. Did the child whose parent or parents participated in the parent group refer to this during sessions with you?

Only one worker said that a child alluded specifically to the parents' group.

2. Do you believe a change occurred in parent-child relationships (positive, negative, or whatever) as a result of the parents' involvement in the group?

Seven workers saw positive changes. One of these commented: "Yes, the mother was better able to

accept her son's growth and see that her need to overmother him was a deterrent to that growth." Another caseworker reported that a formerly undemonstrative mother had just told her daughter that she loved her and wanted her home—the first time she had ever done so.

3. Do you feel that a parent's participation in the group aided or hindered your treatment plan?

All eight caseworkers said they felt the program had aided their plan. For example, one said that participation "clarified some goals or forced movement where it might have taken longer or never come about for a variety of reasons: apathy of parents, apathy or anxiety of worker; also time limitation of workers and their own view of priorities."

4. Did any of the children you are treating whose parents were not participants ever mention the parents' group in any way?

Two such children were reported to have mentioned the parents' group.

The caseworkers were asked to add their criticisms, suggestions, and comments about the project. Six caseworkers said they thought all parents should be offered this kind of service. One commented about a specific case: "It gave this mother the opportunity to feel a part of the treatment team and important in her son's life, though separated from him."

Most of the parents who participated in the project also expressed positive feelings about the group and several said that they were looking forward to its resumption.

In conclusion

Thus the consensus among agency workers and parents seemed to be that the parents' program facilitated the return of children to their homes. An analysis of what occurred identifies the following helpful elements in the program:

1. *Mutual learning experience:*

- Parents learned about the agency operation and the purpose of the treatment plan for their child. They gained insights into their parent-child relationships.

- Agency workers became aware of the parents' feelings of being isolated and intimidated by a seemingly impersonal agency. Some caseworkers recognized that they tended at times to reject the parents.

- Children in care learned that their parents had not abandoned them after all and could effectively intervene in their behalf.

2. *The combination of casework with group work:*

Positive change was accelerated in all cases through the reciprocal triggering and reinforcement processes of the two treatment methods.

3. *Aftercare:*

The continuation of group and casework services after the family was reunited smoothed the transitional period between the parents' dependency on the agency and their resumption of full parental responsibility.

4. *Maintaining lines of communication:*

The continuing contact of the parent group caseworker with the childrens' caseworkers provided for the coordinated treatment of parent and child.

The project, however, was not a controlled experiment based on a predetermined research design. Therefore, we do not know whether either intensive casework or group treatment alone might have produced similar results. Moreover, the fact of receiving special attention from the agency by being selected for participation in the project might in itself have motivated some parents to work more effectively on their problems with their children. Controlled experiments are needed to shed some light on these questions.

Nevertheless, through the project described here St. Christopher's School has been convinced of the value of coordinated group work and casework for parents of children in care. After the closing of the project in March 1969, the agency raised enough money to resume this type of service on a permanent basis in the fall of that year. At the present time eight parents are participating in this combined casework group work service.

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COMBATTING RETARDATION IN INFANTS WITH DOWN'S SYNDROME

ROBERT B. KUGEL

The disadvantages of institutional care for mentally retarded infants and very young children have long worried persons who work in the field of child development. Numerous investigations—by Bowlby,[1] Spitz,[2] Ainsworth and Boston,[3] Tizard,[4] Skodak and Skeels,[5] Skeels and Dye [6]—have called attention to the deleterious long-range effects of early placement of children, whether normal or defective, in a rigid custodial environment where appropriate stimulation is lacking. Since a child may also be prevented from developing to his highest potential in an unloving and unstimulating family environment, the question may be asked as to whether institutionalization *per se* is the deterring factor when an institutionalized child fails to develop intellectually or socially.

In recent years a number of studies have suggested that institutionalization itself is not so much the deterrent to optimal development of the retarded as the inadequacies in the quality of care in most institutions provided for them in this country [7,8,9]—inadequacies especially in mothering, or "nurturing," and in the particular kind of stimulation needed by the child. That some mentally retarded institutionalized children *can* develop both socially and intellectually if provided appropriate care and stimulation in a homelike atmosphere is strongly suggested by an experiment carried out during 1967 and 1968 by the University of Nebraska Mental Retardation Clinical Research Center.

The experiment was an 18-month study of the development of seven very young children diagnosed as having Down's syndrome (mongolism), a condition accompanied by retardation that until recently has been regarded as inevitable and irreversible. With the purpose of determining guidelines for helping such children achieve greater developmental progress, the experiment provided three program ingredients generally lacking in an institutional setting: a homelike atmosphere, enough staff members to make it possible for each child to be assigned a staff "substitute mother," and continuous stimulating and physically strengthening experiences for each child.

A pilot study designed to provide a basis for more extensive research, the experiment used only gross, though meaningful, measurements of progress. There was no control group, but the progress made by six of the seven children was clearly greater than would normally be expected of children in the condition they were in at entry.

The setting

The first step was to modify the clinical research ward so that it would contain the essentials of a homelike atmosphere and still allow the kind of observation necessary for a research study. Set apart from the rest of the university hospital, this ward includes five 2-bed rooms, a day room, a stimulation-play room, a nursing station, and a fully equipped kitchen.

To produce a homelike atmosphere compatible with the research effort, the day room was furnished as a living room with both comfort and stimulation in mind. The floor was covered with red carpeting, not only to make crawling safe but also to give the crawling child strong tactile and visual stimulation. The furniture included upholstered chairs and a sofa also selected with an eye to tactile and visual stimulation; an attractive low round table, for its decorativeness and usefulness; and a television set. Ornamentation included pictures, plants, and flowers, and a colorful bird cage containing a live parakeet.

The playroom was converted into a stimulation room. The floor was covered with a large blue and green shag rug. Other furnishings included brightly colored chairs of various textures. Paintings, vines,

mobiles, and wind chimes were hung strategically to attract the children's attention. Brightly colored rings and squeeze toys were suspended from the ceiling nearly to the floor to be within easy reach of crawling infants. Two chromesteel mirrors were attached to the wall at floor level to enable the children to watch themselves at play. Record players, radios, music boxes, and bells were provided as auditory stimulants. Educational toys to aid in developing spatial orientation and color, size, form and weight discrimination were kept within reach of the children. Other equipment included—

- *For balance*—rocking boat, rocking horse, tumble tub.
- *To encourage motor skills*—wooden chairs, a Jolly Jumper, spring chairs, bolsters, tricycles with special pedal attachments.
- *To stimulate interest*—crib gyms, crib aquarium with live goldfish, squawk boxes.

The bedrooms were made homelike with wall plaques, paintings, plants, small rocking chairs, and tables. Patchwork quilts and pajamas replaced hospital spreads and gowns.

The ward always had an inviting appearance. The staff members supplied appropriate seasonal and holiday decorations. They encouraged visitors to come to the ward frequently to talk to and play with the children so as to widen the children's realm of experience and stimulate their efforts to communicate.

The children

In January of 1967, six children, ranging in age from 4 to 17 months, were admitted to the Clinical Research Ward from the Beatrice State Home where each had been placed before he was 6 months old. The seventh child in the study came to the ward sometime later. All the children in the study group had been diagnosed as having Down's syndrome and displayed retarded social and physical development. However, none had additional physical impairments, such as blindness or heart disease.

The group presented a wide range of adjustment problems that had to be considered in program planning. Although four of the seven children were at least 12 months old, only one child could sit alone or crawl. Four of the children had little or no head control; five had habitually open mouths and protruding tongues; and three turned their palms out awkwardly in a posture characteristic of autistic children. Of the three children with awkard hand posturing, one rocked and hit his head against the floor, and two tended to withdraw from human contact. Another child showed signs of rumination, and still another had a weakness of the left side.

All the children required a diet of pureed food because they could not chew. Most of them gagged or spit out the food when more solid food was introduced. Two were still taking milk from a bottle, and four of the older children refused to take any milk.

Vocalization was at a minimum. However, most of the children cooed and one could say "ma-ma" and "da-da." Three rarely, if ever, laughed or smiled—suggesting that they had barely begun to engage in the socialization process.

Staff and methods

The child-caring staff assigned full-time to the ward consisted of two registered nurses and five nurse's aides—a one-to-one ratio of staff to children, although not all staff members were on duty at the same time. In addition, a physical therapist and an occupational therapist from the hospital's staff worked closely with the children. A pediatrician, a pediatric psychiatrist, and a research assistant from the hospital comprised the research staff.

Before and during the project the research staff held a series of meetings with the nurses and aides to apprise them of the aims and objectives of the project. In these discussions emphasis was placed on the concept that the children in care had great need to experience interpersonal relationships with a *few* caring persons.

The experiment used many of the procedures used by Skeels and Dye in their study of the effects of stimulation on mentally retarded children.[6] While we hoped to achieve success through providing each child with attention to his individual needs, as did these investigators, our program differed from theirs in several ways. In the Skeels and Dye study the children were placed in the care of older patients; in our study each child was assigned a substitute mother from the staff on the basis of mutual preference. Thus in our program each member of the nursing staff had primary responsibility for a particular child. To avoid an institutional image, the staff members of our unit all wore street clothing rather than uniforms.

The children in our program were younger than the children in the Skeels and Dye study—averaging 9.8 months on entry as compared with 19.4 months.

Skeels and Dye directed their efforts toward an increase in IQ, while our experiment concentrated on developing the children's adaptive processes and motor skills. This difference in focus derived partly from the younger age of our children and partly from the difference in the nature of their handicap. While the retardation of the children in the Skeels and Dye study appeared to be the result of cultural and familial influences, our children's retardation derived from a specific organic impairment, a chromosomal aberration, which results in the group of abnormalities that together comprise Down's syndrome.

Down's syndrome is characterized by retardation ranging in degree from moderate to mild, floppy musculature and lack of coordination, and often, upper respiratory or gastrointestinal infections that inhibit development. Our experiment gave priority to the correction of the children's motor problems and the development of skills required for socialization, on the theory that success in these areas would favorably influence the child's mental development in later stages.

Socialization

The program of daily care was designed to provide a broad base of environmental and community experiences like those available to the average middle-class, normal child. The supervising nurse, who helped design the program, instructed the nurses and aides in the proper handling of the children and in the initiation of age-appropriate activities for each child. Since children's needs change so rapidly in early childhood, she held instruction sessions weekly.

From the beginning, a nursery school program was held on the ward for an hour each morning and afternoon, except for two mornings a week. During these sessions, each child's substitute mother would work with him on developing various skills and carrying out the exercises recommended for him by the physical therapist. In these sessions the children were also encouraged to play with each other and to use the appropriate growth-inducing toys as soon as they were ready for them.

The child's experiences in the unit also included the kind a child would have in his own home in the routine of daily living—as an infant, being dressed and fed, and later, learning to feed himself and to help when being dressed and undressed; playing with other children; having parties for special occasions; and learning the limits of acceptable behavior. Everything done by the staff in dealing with these routines was done with a developmental purpose. Since consistency has proved to be helpful in teaching mentally retarded children, most activities that involved daily routines were presented in a structured manner. For example, the nurses and aides always dressed the children in the same way.

The staff members provided the children with many new experiences away from the ward. They took the children with them on biweekly shopping trips and for visits to public buildings, the zoo, and other interesting places. Twice a week—on the two mornings when there was no nursery school program on the ward—they took them to the nearby C. Louis Meyer Children's Rehabilitation Institute for swimming lessons. These lessons were given to all the children, even those under 6 months old.

By the time spring arrived, all the children were old enough to play in the center's well equipped playground. In the fall they began to attend a prenursery school at a local church, thus becoming acquainted with normal children. Some of the children also participated in children's birthday parties or holiday festivities in staff members' homes.

The special attention and stimulating experiences afforded each child, along with rewards of smiles and praise for the child's activities, brought these children to a higher degree of sociability and adaptability than had been observed in children of the same ages with Down's syndrome confined to the State home.

Our records show that at the time of admission, one 12-month-old child related very well to others; another year-old child seemed happy but did not relate well. The rest of the children were extremely lethargic; they barely looked at interesting or moving objects and barely responded to the advances of adults or other children. Two of the children displayed some autistic behavior. The records also show that within 2 months, all but one of the children were

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laughing and smiling in response to other voices and to play. The one child who was 17 months old when admitted to the project had learned to respond a little but not as well as the others. However, after about a year this child suddenly began to respond to a new "mother substitute"—a nurse's aide—and from then on made rapid progress.

Motor skills

The physical therapist and the occupational therapist, working as a team, played a major role in the experiment. They observed each child weekly to determine the child's particular needs for developing motor skills and coordination. On the basis of their observations, they would decide on a management plan and instruct the aide in charge of the child in the techniques it required.

The physical therapist also drew up some general guidelines for developing the motor skills of the children in the group. Using the guidelines for normal development as a base, he indicated the areas of physical retardation that inhibit the total development of the child with Down's syndrome and the kinds of efforts that can help overcome these problems. All the therapeutic activities he recommended were also intended to increase the child's awareness of self and environment. Their basic purpose was to help the child develop—

Head and neck control. Most children with Down's syndrome have poor neck control and as a result their heads lag awkwardly. When such a child is propped up in a sitting position or is learning to pivot in a prone position, he tends to extend his neck at an extreme angle.

To reduce head lag and develop muscle tone in the neck, the nurses and aides, under instructions from the physical therapist, allowed the child some freedom of head movement when picking him up from a supine position; they fed the child with his head held in a midline position; and they gave him exercises and activities that required him to move his head.

Sitting. When the child with Down's syndrome first begins to sit up, he spreads his legs wide from the hips and leans forward with his head extended back. These children usually do not rotate to a sitting position, as do children normally, but instead, push themselves up with their arms from a prone to a sitting position, an indication of excess body tension. The inability to rotate is likely due to shortness of the upper extremities and poor trunk tone.

The nurses and aides helped children overcome these difficulties by patiently guiding them through the proper motions for shifting from a prone position to creeping, and then to sitting propped with the hands as does a normal child. When a child learned these movements, his general mobility was greatly increased.

Creeping. Children with Down's syndrone generally display low muscle tone and a marked degree of rigidity in the legs, which make it difficult for them to assume a creeping position.

Therefore, as each child in the unit showed a readiness to creep, a toy skate-board was used to support his abdomen and chest. Most of the children learned to propel themselves in this position by moving their arms, but few used their feet, knees, or ankles to push. To correct their ankle weakness, the children were often put in jump seats or in stationary seats that would allow them to push their feet against the floor. As the children gradually progressed to the crawling stage, they were encouraged to crawl over and around large objects, like the rocking boat.

Standing and walking. The same problems of muscle tone and mobility had to be corrected in regard to standing and walking. These problems made it very difficult for the children to pull themselves to a standing position. As muscle tone and mobility improved, however, some of the children learned to pull themselves up and some moved quickly from there to walking. As a child learned to walk he was encouraged to push wheeled, weighted wagons and carts to strengthen the muscles used in standing and walking.

After 6 months in the program six of the children could walk well and even run and climb. They were then encouraged to engage in activities that develop fine motor skill—for example, putting balls into bottles, fitting keys into locks, and building with blocks. The children also developed fine motor skill through structured play, such as finger games and nursery rhymes that require particular movements. Several of the children learned such movements quickly.

The physical and occupational therapists kept progress notes on each child's motor development. In addition, the child's developmental abilities were recorded monthly on film and assessed against the Gesell developmental scale.[10]

At the end of the program's first year, all of the children could pull to a standing position; three

could walk, climb on furniture, and walk up and down stairs, and four were beginning to ride tricycles. All of the children could float in the swimming pool, two could swim across the pool, and two could surface dive.

Progress generally had been good, and in some areas, better than the program planners had expected. The children were functioning up to age in gross motor activities; in fine motor activities they were slightly below the norm for their chronological age. For most of the children, adaptive behavior and even language development were appropriate for their ages; most of them had developed some self-help skill in feeding, dressing, and undressing; and some were beginning to show a little progress in toilet training.

Some implications

The experiment clearly showed that a hospital routine can be changed to be fully supportive of the development of young children. Much of the success accomplished in motor development can be credited to the sensitivity and persistence of the caretaking staff. While the physical and occupational therapists instructed the nurses and aides in developmental methods, these mother substitutes had to be alert to the best ways of motivating each child. They also proved well able to simulate the kind of care a normal, successful mother would provide.

In addition our findings thus far, though based only on a small sample, have added to the accumulating evidence that retarded children will develop better if provided with age-appropriate stimulation. It is too early, of course, to tell whether the gains made in the child's early life will affect his later development.

The Clinical Research Center plans to follow this pilot experiment with a scientifically rigorous study of three types of care. We plan to study three groups of 10 children each, all with Down's syndrome. One group will be cared for at the State Home in the usual manner; another will be reared at home by their parents; and a third group will be cared for in the manner described here.

In the meantime all the children of the pilot study have been placed in foster family homes near the hospital. Their progress will be followed closely by the research unit for at least 3 years so that developmental assessments of the children can be made in their critical second and third years of life. By the time they are 3 or 4 years old, it should be possible to make reliable assessments of their adjustment and intelligence.

What of the children's parents? All of them had followed a physician's advice soon after their child's birth to place them in an institution as soon as possible. Therefore, they had had no opportunity to form any deep relationship to the infant. When asked permission to transfer the child from the institution to the experimental ward, not one parent objected. After the transfer some parents began visiting their children frequently. They were encouraged to take their children home for weekends or out for rides and visits, and some of the parents did so. None, however, asked to take his child home permanently.

Our study has produced material for working with children with Down's syndrome that can be helpful to parents or foster parents who have such children at home. The physical and occupational therapists have already applied the methods they developed on the basis of the observations in this study in teaching parents to work with their children themselves, with much success.

Perhaps this experiment will help convince professional people who influence parents' decisions about their retarded child that much can be accomplished with mentally retarded children when help is available. It may also convince policy makers of the advantages of providing individualized care for retarded children in small groups when family care is not possible for them.

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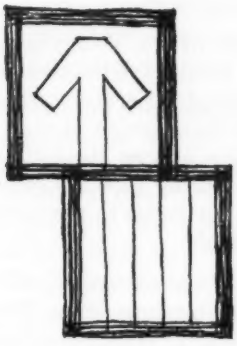

HEAD START'S INFLUENCE ON COMMUNITY CHANGE

LOIS-ELLIN DATTA

In a small northern community, the prevailing general attitude was that the poor are no different from the more affluent—"just lazier." Private physicians alleged that the poor seemed able to afford everything except good medical care for their children, and that if these parents budgeted their money more efficiently, they could afford the health care their children needed. In this conservative town, the general opinion was that each family should pay for what it receives, including medical care. No public health programs existed; nor was there an immunization program, or a maternity or well-baby clinic.

In a predominantly black southern community, a school system now operates a comprehensive health clinic. The clinic is financed almost entirely by Federal funds. This school system has altered its traditional role of educator to include that of health-care provider as well. The idea for a health-care facility was generated by a nurse who realized the need for such a program after examining [Head Start] project enrollees, most of whom exhibited symptoms of chronic disease and malnutrition. Many had never been examined by a doctor. The nurse presented these facts to public health and school officials and requested their help in finding a solution to the problems. Together they worked out a plan whereby the school system would apply for Federal funds to establish and operate two health clinics for children.[1]

The small northern community was one of a sample of seven without Head Start programs described in a recently completed report of the impact of Head Start on community institutions by Kirschner Associates, Inc. The southern town was one of a sample of 58 communities in which full-year Head Start programs were operating in 1968.

The possibility that programs may produce effects beyond those expected for the people directly served is happy but unanticipated for some, a sustaining hope for others, and a primary goal for still others. Reports of institutional change associated with new projects and ideas have appeared frequently since the wave of New Deal social reforms of 1933–1937. Only recently, however, have systematic investigations been initiated to determine to what extent and how social action programs actually change established institutions.

Project Head Start began in summer 1965 as a program to improve the opportunities and development of the children of the poor. The main focus was on the child himself: improving his physical health, his social and emotional development, his relationships with his family and theirs to him, his sense of worth as a person, and his cognitive and linguistic skills. The approach to these goals was consistent with that of the Community Action Program (CAP), of which Head Start was a part.

The objectives of CAP included the provision of direct service to the poor. More broadly, through the mobilization and participation of the people served and the integration of the new programs with other community organizations, CAP strove to create agents for social change in the structure of the community that could endure and spread beyond CAP's direct reach. Head Start's concern for the well-being of children implied even longer-range goals—influencing the philosophies, practices, and activities of other community institutions to become more responsive to the needs of the poor and their children.

The Kirschner study involved extensive interviews with persons involved in Head Start programs,

CAP, the school system, health services, and persons with related concerns in 58 communities selected to represent significant Head Start variations—in geographic area, size of the community, type of agency operating the Head Start program through delegation of responsibility, and degree of control exercised by the parents of the children served. Seven comparison communities, with no Head Start programs but matched as well as possible to seven sample Head Start communities, were studied in depth. The researchers found few beneficial changes in the comparison communities while the communities with Head Start programs had undergone many changes since 1965. Local Head Start programs were reported to be influential in bringing about these changes.

A total of 1,496 changes related to Head Start objectives were identified in the 58 communities studied. In over half these communities, more than 25 changes were noted. Of these changes—

- 305, or 20.3 percent, reflected increased involvement of the poor with community institutions, particularly in decisionmaking capacities. For example, in a small southwestern village, a group of Spanish-speaking parents of Head Start children has formed a grassroots organization to exert pressure for changes in school policies and practices. Currently at issue is the school system's regulation *against* students bringing their lunches to school instead of buying them there, even though many children who cannot afford to buy lunches at school must go hungry.

- 51, or 3.4 percent, involved greater employment of neighborhood persons in paraprofessional positions.

- 747, or 50 percent, showed greater educational emphasis on the particular needs of the poor and minorities. For example, a midwestern school system has placed social workers in predominantly black innercity neighborhood schools. Most of these new staff members are black.

- 393, or 26.3 percent, indicated modification of health services and practices to serve the poor better and more sensitively.

Head Start's influence

The fact that salutary change took place in a community with Head Start programs is not compelling evidence that Head Start made a difference in the change. To investigate the role of Head Start, if any, a survey was made of the dynamics of 47 specific changes in 42 of the 58 communities. In the origin of 44 of the 47 changes, Head Start was found to have had a positive influence.

- In 78.7 percent of the 47 changes, the Head Start program was involved in the background stage of change. For example, a school system began to concern itself with malnutrition of poor children—a prevalent condition among Head Start children that came to light during their physical examinations—by applying for funds to provide a hot meal and snacks in the schools.

- In 34 percent of the changes, Head Start participated in the idea-proposal stage. For example, when a large proportion of Head Start enrollees were discovered never to have had immunizations, the Head Start director instigated a persistent campaign that brought about enlargement of the health department's immunization program—for smallpox, measles, polio, and the combined diphtheria, pertussis, and tetanus (DPT) series.

- In 68.1 percent of the changes, the Head Start program was involved in the third stage—support for change adoption. For example, in a western town where a large Spanish-American community felt that the school system had discriminated against their children, Spanish-American parents allied themselves with other active minority groups to campaign for—and elect—a slate of school board candidates who were sensitive to their problems.

- In 8.5 percent of the 47 changes, Head Start was active in the authorization stage. For example, in a small southern town, the Head Start program fought for and won approval from the Office of Economic Opportunity to use Head Start funds to have the local health department administer the Head Start program's medical component, thus making it possible to hire new staff, centralize records, and increase parent contact to the benefit of many low-income children in the community.

- In 12.8 percent of the changes, Head Start was involved in the provision of resources stage. In one large midwestern city Head Start provided training for paraprofessionals employed in various community health services.

- In 21.3 percent of the changes, Head Start was involved in the execution stage. For example, many of the kindergarten teachers in a large city school

system in the west have modeled their classroom scheduling after the Head Start program through the influence of teachers who had formerly been with Head Start and brought the new, less rigid techniques used in the Head Start centers with them to the regular school system.

- In 72.3 percent of the changes, Head Start supported the execution of change. For example, in a northeastern city, Head Start parents and staff helped overcome local resistance to "outsiders" staffing a new health clinic by holding meetings in their homes and inviting other area residents to hear discussions of the clinic services and to meet the members of its staff.

Degree of involvement

The Kirschner report showed that—

- The more stages of change in which the Head Start program participated, the greater the benefit, scope, and duration of the change. For example, in a southern community where Head Start was involved only minimally in the development of a teacher aide program for the schools, teacher aides were employed mainly for the clerical work involved in transferring black students' records to formerly all-white schools in the year the schools were desegregated. The following year when less money was available for the school system, some of the aides, most of them black people with low incomes, were dismissed.

In another community, the idea of having teacher aides in the schools was proposed by teachers who had taught in a local Head Start program. School administrators reported that the aides, who were poor people recruited from low-income neighborhoods, were responsible for a noticeable improvement in the children's motivation to learn and for better communication with the parents of low socioeconomic status. As a result of the success of the teacher aide program, school officials applied for funds to hire community aides from low-income neighborhoods (another Head Start practice) to visit the pupils' homes and further strengthen the link between the classrooms and the children's impoverished families.

- Head Start programs were equally effective as change agents whether they were operated by public schools or new agencies established for the purpose.

- A high level of parent participation in the Head Start program (defined as a high ratio of nonprofessional to professional staff and parent control over selection of staff members) was associated with high involvement of the Head Start program in bringing about institutional change.

- High involvement in change was also related to a high degree of visibility of the Head Start program and its willingness to relate to other local agencies and institutions—that is, where serving as a change agent was specifically defined as part of the local Head Start's program role.

Another finding underscores the complexity of social change. It appears that a "critical mass" for producing social action may be reached in a community with a climate conducive to change and an active Head Start program that sees itself as mobilizing agent. Such a community climate is associated with civil rights activities, the interest and influence of community and professional leaders, and the availability of Federal and State funds to meet the needs of poor children.

These findings buttress the results of a recent study of the Community Action Program as a whole.[2] This study, involving about 100 cities, showed that local Community Action Agencies (CAA's) play two sharply contrasting roles: (1) mobilizing and organizing the poor so that they may make known their needs and interests on matters of public policy and institutional improvement, and (2) supplementing and aiding the efforts of community service agencies. CAA's adopting the first role "were clearly more effective in bringing about institutional change than those that emphasized a service role." In both the Head Start and CAP studies, the researchers emphasize that mobilizing the poor is *not* a militant protest activity, although it may coexist with militancy, but that it "typically involves activities which are well within the boundaries of traditionally accepted and encouraged legitimate political activity: petition-

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Lois-ellin Datta, chief of the evaluation branch of the Research Division, Office of Child Development, joined the staff of Head Start in 1968. From 1963 to 1968, she was a senior research fellow, then a research psychologist on the intramural staff of the National Institute of Mental Health, participating in a laboratory of psychology study on creative adolescents. She received her Ph. D. in psychology from Bryn Mawr College.

ing for redress of grievances, presenting testimony to public policy-making bodies, the enlistment of allies with similar interests." [2]

Further questions

Retrospective studies, relying on the recall of informants and sensitive to the social climate of the research, are inevitably limited sources of information on how programs such as Head Start can change established institutions. Prospective studies, particularly those in which variations in the factors thought to be significant are experimentally introduced, are needed to provide surer and deeper knowledge of the process of role definition and of the pervasiveness, persistence, and longer-range impact of changes introduced.

Within these limitations, however, there seems to be evidence that Head Start and other aspects of Community Action Programs have indeed played significant roles in effecting institutional change. The Kirschner Report concludes:

One can truly say that these institutions are still not fully responsive to the poor, that the local commitment to change has not been backed by local dollars, and that the available educational and medical technology is not adequate to the needs. But . . . in a short time, with a relatively small investment (less, in toto, per year than the education budget for a state such as New Mexico) Head Start has been closely associated on a national basis with the development of fundamental change in educational and health institutions, two of the most crucial institutional groups in the country.

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guides and reports

FOSTER CARE IN QUESTION: a national reassessment by 21 experts. Helen D. Stone, editor. Child Welfare League of America, 44 East 23d Street, New York, N.Y. 10010. 1970. 275 pp. $4.20.

The first part contains "working papers," prepared by a Practice Commission on Foster Care, that examine the theory bases of foster care practice; the second part, selected papers from the first National Conference on Foster Care in New Orleans, La., in 1967.

SECOND THOUGHTS ABOUT YOUNG PEOPLE. Greater Philadelphia Federation of Settlements, 1315 Walnut Street, Philadelphia, Pa. 19107. 1969. 57 pp. $1.50.

Reports on a 2-day conference of people engaged in Philadelphia's Project MOVE, on why a youth program succeeds or fails, with special reference to "black rage and youths, institutional hypocrisy, action by adults, new roles for youth workers."

FOSTER FAMILY PARENT EDUCATION. Mary Jane Nowak and Mary Reistroffer. University Extension Service, The University of Wisconsin, Department of Social Work, Milwaukee, Wis. 53211. 1970. 68 pp. $3.

Describes a model for group education of foster parents developed at the University of Wisconsin, presenting sample class units and suggested teaching materials, including a bibliography.

ILLEGITIMACY: changing services for changing times. National Council on Illegitimacy, 44 East 23d Street, New York, N.Y. 10010. 1970. 98 pp. $3.25.

Consists of seven papers presented at the 1969 National Conference on Social Welfare, including reports of followup of mothers who keep their children, ethnic variations in views and practices concerned with births out of wedlock, social factors causing illegitimacy, and the use of research in programs.

COMMUNITY PREPAREDNESS FOR RETARDATES: Ralph M. Scheer, Sharryl Hawke, and Norman G. Rice. Austin State School, Post Office Box 1269, Austin, Tex. 78767. 1969. 103 pp. $1.

Presents a program of instruction to help mildly retarded young people adjust to the world outside the institution.

GROUP WORK SERVICES AMONG PREGNANT ADOLESCENTS IN THE INNER CITY. Crittenton Comprehensive Care Program. Florence Crittenton Association of America, Inc., 608 South Dearborn Street, Chicago, Ill. 60605. 1969. 30 pp. Free.

Describes the processes and goals of group discussions with pregnant school-age girls led by social workers and nurses in the Crittenton Comprehensive Care Center in Chicago.

HERE and THERE

4-C program

Twelve State and local Community Coordinated Child Care (4-C) organizations have been officially recognized by Federal Regional Interdepartmental 4-C Committees, officials in the Office of Child Development said in mid-July. Under Federal guidelines, the recognized 4-C organizations will help to coordinate all day care and other preschool activities carried out by public, voluntary, and commercial agencies in the areas they serve. ("The 4-C Program," by Jule M. Sugarman, CHILDREN, March-April 1969).

Parents of children receiving services are fully represented on policy committees of the 4-C organizations.

About 100 communities have established steering committees for the development of a coordinated approach to child care, a major step toward official recognition. At least 100 other communities have held an initial interagency committee meeting or requested information on how to organize and operate a 4-C program.

The recognized 4-C organizations include State committees in Massachusetts, New Hampshire, and Vermont, and local committees in Holyoke, Mass.; Gary and Indianapolis, Ind.; Waco, Houston, and San Antonio, Tex.; McAlester, Okla.; El Dorado, Ark.; and Seattle, Wash.

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During fiscal 1970 grants totaling $100,000 for short-term training of day care and early childhood personnel in agencies participating in 4-C programs were awarded to 16 colleges and educational centers by the Community Services Administration, Social and Rehabilitation Service.

The grants will be used for institutes and workshops that focus on quality day care, dialogues between users and providers of day care, evaluations of current training techniques, and development of future training and licensing programs as well as training of workers in rural and urban centers. Grants have been awarded to Wheelock College, Boston, Mass.; Southampton (N.Y.) College; Westchester Community College, Valhalla, N.Y.; Virginia Polytechnic Institute, Blacksburg; Georgia State University; University of Mississippi; City College of Chicago (Ill.); Grand Rapids (Mich.) Junior College; Kansas State University; Wichita (Kans.) State University; Chadron (Nebr.) State College; Oklahoma City (Okla.) University; University of Montana; Colorado State College; Center for Early Childhood, Los Angeles, Calif.; and Pacific Lutheran University, Tacoma, Wash.

Teenagers and children

A two-day conference of 60 people was convened in Washington in mid-July by the Office of Child Development to discuss ways of helping young people learn about children's needs through direct experience with them. The participants included child development specialists, social workers, educators, other professional persons, and teenagers who were working with younger children in programs some of them had devised themselves. Of the many points of view they expressed, one was clearly unanimous: opportunities for adolescents or older children to work with younger children in educational, recreational, or child care programs can be developmentally advantageous to each.

At the opening general session Edward F. Zigler, director of OCD and chief of the Children's Bureau, asked participants to make concrete suggestions for a possible federally funded project. Three speakers set the stage for the ensuing group discussions: Ronald Lippitt of the University of Michigan told of experiments in cross-age associations in the Michigan public schools indicating that children can be greatly influenced by those who are 3 to 5 years older than themselves and that there is a "great readiness" among teenagers to work with younger children; Beatrice Whiting of Harvard University described cultures in which children have responsibility for younger children from the age of 5 and as a result develop sensitivity to others from an early age; Urie Bronfenbrenner of Cornell University told of various ways in which Soviet schools promote a sense of responsibility in children, including the practice of having each class be responsible for providing tutorial help and recreational opportunities to children in a younger "adopted" class.

In the four work groups many of the participants expressed doubts that a high school course labeled as a course in parenthood would appeal to young people—or would reach those who might need it most, the high school dropouts. Good parenthood, a number of participants suggested, requires a sensitivity to others that cannot be taught but grows out of a kind of meaningful experience that the schools cannot provide unless they first "become humanized" themselves. Some participants also strongly advocated local participation and the inclusion of teenagers in planning for any project that might be launched, to assure that it is culturally relevant and gives teenagers a meaningful role.

In a panel discussion of teenagers some of the young people expressed strong hostility toward the schools and said they wanted no part of any project that they did not control themselves.

At the final session, the chairman of the conference, Jerome Bruner of Harvard University, drew up a list of "antimonies" from the work groups' reports in which consensus seemed to have been reached regarding any program that might emerge from the conference. In brief they were—

• The program should be carried out outside the school, but should involve the school.

- It should provide teenagers with direct experience with children rather than didactic instruction, but should be supported by materials and experts.
- It should be initiated by young people, but should have a connection with other aspects of the community.
- It should provide a way for young people to help those younger than themselves, but should satisfy their own and community needs.
- It should be locally controlled, locally initiated, culturally plural, but should deal with the universals of child development.
- It should be spontaneous, but should offer school credit and payment.
- It should serve the teenager, but should do genuine service to the very young.
- It should stimulate preparation of materials for local use, but should also make the possibility of such materials known to other local groups.

Family planning

At its spring meeting this year the UNICEF Executive Board for the first time authorized the agency, when requested, to distribute contraceptive supplies to countries being assisted by UNICEF for maternal and child health services in which family planning is an integral part. This decision came after the executive director reported that contraceptives were not readily available to all these countries from other sources.

In 1966, when UNICEF approved a program of assistance in family planning, the supplying of contraceptives was deliberately excluded to avoid controversy and because it then appeared that adequate supplies were available from other sources.

The World Health Organization, which provides technical approval for UNICEF-assisted projects, supports the new policy.

Teens for tots

High school students will be working directly with preschool children in innercity areas during the 1970–71 school year under three Teens for Tots demonstration projects, one in Little Rock, Ark., supported by the Children's Bureau, and two in Chicago, Ill., and San Antonio, Tex., supported by the Sears Roebuck Foundation of Chicago.

The projects are being carried out by the grant recipients—the school system in Little Rock, with a grant of $83,786 that provides for continuing evaluation of all three projects as well as operation of a local Teens for Tots demonstration: the school system in Chicago, with a $46,325 grant; and the Agricultural Extension Service of Texas A&M University with a $44,008 grant for the San Antonio demonstration.

Under the projects, students will be taught basic principles of child development while working with young children and their parents. Objectives of the projects are to enhance growth and development of young children, to teach teenagers ways to facilitate interaction between parent and child, to develop new career opportunities relating to child care, and to prepare teenagers for roles as parents. Although each project has a different focus, all are adapted from models of ways to promote interaction between young children and their parents, developed with the support of Children's Bureau research grants.

In Little Rock about 400 high school boys and girls will work with groups of 5-year-old children and their families as a part of a 1-semester home economics course in family and child development. They will serve as observer-helpers in kindergartens established in two high schools and operated by the Center for Early Development and Education, an agency jointly sponsored by the Little Rock School District and the University of Arkansas. In addition, eight students will be trained for careers as day care assistants through a diversified occupations program. All the students will receive pay for their work with the children and academic credit for classwork. A summer job placement service for students interested in careers in day care will also be established.

In Chicago 30 boys and girls at the John Marshall High School will become infant educators, working in a one-to-one relationship with 30 children under 3 years of age and serving as teaching models for their mothers during biweekly sessions at a neighborhood center. The students will earn academic credit for a course in child development and will receive pay for their work at the center. They will also observe preschool children and assist teachers in Child-Parent Education Centers run by the school system.

In San Antonio 30 Mexican-American boys and girls between 13 and 16 years of age will work in teams of two under the direction of an extension agent. Making two visits a week to the home of a child between the age of 6 months and 2 years, each teenager will spend at least 1 hour interacting with the child and his mother while the other team member will serve as observer-recorder. In the second visit, the two teenagers will exchange roles. Every 2 weeks the teenagers will attend a group seminar to discuss their ideas, needs, and development of the children. Because their work will be focused on the young Mexican-American child's verbal development and concept formation, only bilingual teenagers will be selected.

All three projects include the development of materials and curriculum.

Court decisions

Juveniles who are charged with violating a criminal law are entitled to the constitutional safeguard of proof beyond a reasonable doubt, just as adults are, according to a recent ruling of the Supreme Court of the United States. In a 5–3 decision handed down on March 31, the court held that "the same considerations which demand extreme caution in fact-finding to protect the innocent adult apply as well to the innocent child." The majority opinion, written by Justice William J. Brennan restated other safeguards to which a juvenile defendant is entitled: notice of charges, right to counsel, the right of confrontation and examination, and the privilege against self-incrimination.

The Court ruled unconstitutional the part of the New York Family Court Act that provides that determinations in juvenile hearings be based on a preponderance of evidence, the standard of proof required in civil cases.

The case was brought on behalf of Samuel Winship, who at the age of 12 in 1967 was charged with stealing $112. He was committed to a training school on the basis of "preponderance of evidence" standards, although the family court judge noted that the evidence did not meet the adult standards of "reasonable doubt."

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The Supreme Court also issued two decisions last spring regarding State policies in the program of aid to families with dependent children (AFDC)—one allowing States to set a maximum on family grants and the other prohib-

iting the reduction of support for a child because of the presence of an unrelated man in the home.

In the case of *Dandridge v. Williams*, the Court by a 5-3 decision overturned a ruling of a Federal district court that had declared invalid Maryland's regulation setting a $240 or $250 maximum on grants regardless of the size of the family. (See CHILDREN, March-April 1969, p. 78.) The Court held that a State does not violate the Social Security Act "so long as some aid is provided to all eligible families and all eligible children," and that it does not violate the Equal Protection Clause of the Constitution merely because the classifications made by its laws "in the area of economic and social welfare" are imperfect, if they are made on a "reasonable basis."

In the case of *Lewis v. Martin*, the Court in a 6-2 decision ruled valid a regulation of the Department of Health, Education, and Welfare that prohibits States from presuming in their compilation of AFDC budgets that a nonadopting stepfather or man assuming the role of spouse to a woman although not legally married to her is providing support for her child. The regulation had been declared invalid by the State of California. In reversing a decision of a Federal Court in San Francisco, the Supreme Court held that unless it could be shown that such a man was actually contributing to the child's support, the State was not free to consider his income in determining the child's need for assistance "whatever the nature of his obligation to support."

White House Conference

Selection of the 4,000 delegates to the 1970 White House Conference on Children to be held in Washington, D.C., December 13–18 will be completed in September. The conference staff and cooperating agencies are making special efforts to insure representation of all segments of the nation concerned about children under 13 years of age. One-third of the conference participants will be under 24 years of age.

Governors will appoint official delegations to the conference from each of the 50 States and the U.S. territories. Other participants will be drawn from national professional and voluntary organizations, government agencies, industry, and private citizens.

To assist in preparation for the meeting, the conference appointed a 20-member coordinating committee in July, composed of 12 adults and eight young people from State committees and voluntary organizations.

Views of how elementary school children view themselves and their world will be presented at the conference through a film, "I'm Me," to be composed of movies taken by children of their own surroundings, skits written, directed, and acted by children, and animated sequences prepared by children; and through a publication featuring art, poetry, and prose created by children under 13 in 11 school districts from Hato Rey, Puerto Rico, to Portland, Oreg.

Hospital care

Parents and medical students have generally approved of an arrangement whereby the parents care for their hospitalized children, but physicians have found that the arrangement makes little difference in the understanding of their communications to the parents about the sick child, according to a pilot study, carried out in 1968, of the experimental Care-by-Parent Unit at the University of Kentucky Hospital in Lexington. The Care-by-Parent Unit consists of 14 private rooms where the mother lives in with the sick child; a nursing station manned by two child care assistants; a lobby; and a utility room for the parents containing a refrigerator, a range, a washing machine, a dryer, a bathinette, an iron, and an ironing board.

The study was carried out under the direction of Melvin J. Lerner, Ph. D., of the College of Medicine's Department of Behavioral Science with a grant from the Children's Bureau. It was preliminary to a larger research plan to determine the effects of an experience in the unit on physician-parent communication, on the family, and on medical education.

The pilot study involved interviews with the parents and physicians of 45 patients. The physicians, on the whole, reported that the parental understanding of their communications about the child's condition and treatment needs was about "average." The study found, however, that the parents had better understanding of the physician's diagnosis than of the prognosis or of the requirements of aftercare. A comparison of the interviews revealed a wide disagreement between parents and physicians about the physicians' expectations regarding the followup treatment of the children at home, especially in relation to diets and medications.

While the study found that the parents seemed more satisfied than dissatisfied with their experience on the unit, it also found that the more specific the questions asked, the more likely they were to elicit criticism.

The effects of the Care-by-Parent Unit on medical students was studied through questionnaires. It was found that an overwhelming majority of the students who had experience in the unit preferred it to the general pediatric ward as both a teaching and patient-care facility. However, many of them criticized the unit's lack of nurses or equipment to care for acute problems. Some students criticized the unit as a teaching section because it did not include patients with acute illness—seriously ill children are assigned to the general pediatric ward. The study found that the medical students liked the increased responsibility given them on the unit to become involved with the patients and their parents.

Foster care

A National Conference of Foster Parents, the first of its kind, will be held in Dearborn, Mich., November 13–15 under the sponsorship of the Children's Bureau, Office of Child Development. About 150 foster parents are expected to attend. In addition there will be about 50 observers from State and voluntary agencies that deal with foster family care. The Christopher Street Society, an organization of foster parents in Detroit that suggested the calling of the invitational conference, is preparing the agenda on the basis of answers to a national mail survey of foster parents and agency workers.

Group programs to prepare foster parents to help the children in their care are feasible for child welfare agencies to undertake, a four-member research team at the Boston College Graduate School of Social Work has concluded after conducting a 2-year

demonstration project involving group education of foster parents.

The project, which was carried out from 1967–69 with support from the Children's Bureau, developed and tested methods of educating foster parents in groups and preparing social workers to lead such groups. The social workers from child welfare agencies attended weekly seminars to learn techniques of adult education and group work and the rationale for foster parent education. At the same time, each social worker conducted an educational program for foster parents, who responded readily to such efforts.

As a result of the project, the school has published "A Guide for Foster Parent Group Education," by Albert F. Hanwell, Mary A. Mason, project director, Mae T. Mooney, and Carolyn Thomas. The first section of the guide presents basic materials for fifteen 2-hour classes for social workers. The second section presents an outline for a 12-session course for foster parents.

Copies of the guide may be obtained from the Boston College Graduate School of Social Work, McGuinn Hall, Chestnut Hill, Mass. 02167. (Price: $1.50.)

Adoption

About 101 approved adoptive homes were available in 1969 for every 100 children needing adoption, according to a survey of public and private child-placing agencies in the United States and Canada made by the Child Welfare League of America in early 1970. The 261 agencies in the survey reported having 32,645 homes approved and 32,288 children available for adoption.

However, in her report, Lucile J. Grow, the study director, suggests that a breakdown according to the characteristics of the children would show great variations in the pattern, ranging from an appreciable excess to an extreme shortage, depending on the children's age, sex, religion, physical or mental condition, and, especially, race. Data on all these variables were not obtained in the study.

The study did show, however, that the pattern varied with the type of agency—whether it was public or private and whether it was under religious auspices. Among voluntary agencies, Jewish agencies were found to have the greatest excess of approved homes over adoptable children and Catholic agencies the least. Public agencies, on the other hand, reported fewer homes than children.

All types of agencies, however, reported a large deficit of approved nonwhite applicants for children and a surplus of approved white applicants. About 116 homes of white families had been approved for every 100 white children available for adoption, but only 39 homes of nonwhite families for every 100 available nonwhite children, most of whom were black. The data showed that the agencies were more likely to approve nonwhite applicants as prospective adoptive parents than white applicants: the medians were 61 percent of the nonwhite applicants and 49 percent of the white approved. No information was obtained on whether some of the white applicants would be willing to accept black children.

Deficits of approved homes to total available children were found in Canada, and the Middle Atlantic and Pacific States.

In her report, "New Look at Supply and Demand in Adoption," Dr. Grow warns against accepting the findings of the survey without question because of the variation in what agencies consider an "application" or what kind of a child is considered as "available" for adoption.

The report is available from the Child Welfare League of America, Inc., 44 East 23d Street, New York, N.Y. 10010. (Price $1.).

For the retarded

Since the summer of 1969, a librarian from Adriance Memorial Library, Poughkeepsie, N.Y., has been making regularly scheduled visits to the Dutchess County Mental Health Center to conduct a story and music period for severely retarded children and adults. The program is conducted by Esther Kando Odescalchi, head of the library's extension service.

Mrs. Odescalchi visits the center once a week in the winter and twice a week during the summer taking along books, films, and phonograph records appropriate for young children. She usually conducts two 30-minute story and singing sessions, each with about 15 patients.

The listeners range in chronological age from 5 to 30 years. Many of them are confined to wheelchairs because of physical handicaps, such as cerebral palsy.

Because of her listeners' short attention span, the librarian tells stories that only last about 10 minutes. She selects a narrative that is easy to follow and omits confusing details. Speaking to each member of the group by name, she encourages interruptions and questions and also asks questions of her listeners. She walks around the semicircle to show pictures and to let each person touch the book. She has found that the children are fascinated by stories of witches, flying horses, dragons, and other supernatural creatures.

After the first story, the librarian plays familiar songs on the piano. She has found that the children—even those who do not speak—generally respond enthusiastically to music.

Child abuse

A total of 586 suspected cases of child abuse were reported to the Pennsylvania Department of Public Welfare in 1969, an increase of 3.2 percent over the 568 cases reported in 1968.

Under Pennsylvania's child abuse reporting law, physicians must file a written report with the county child welfare agency whenever examination of a child under 18 discloses evidence of gross physical neglect or injury that may have been inflicted by another person.

Forty-nine of Pennsylvania's 67 counties reported one or more cases of suspected child abuse for the year 1969. Among the injured children males exceeded females by a small margin. Swellings, bruises, and welts were listed as the most common diagnosis; beatings, fractures, and burns, as the most frequent types of abuse.

The greatest number of abused children were in the age group 5–9—a change from the previous year when the highest incidence of abuse was among 1- to 2-year-olds.

Protective services by child welfare agencies were provided for 58.2 percent of the children reported as abused in 1969; 10 percent were removed from their homes at least temporarily.

The abused child's mother was most frequently listed as the suspected abuser followed by the father and stepfather. One fifth of the suspected abusers had been involved in previous cases of child abuse.

BOOK NOTES

ANOREXIA AND OBESITY. Christopher V. Rowland, Jr., M.D., editor. Vol. 7, No. 1, International Psychiatry Clinics. Little, Brown and Company, Boston, Mass. 1970. 360 pp. $8.50.

Two psychophysiological disorders that occur in children as a result of improper food intake are examined in this book by research workers in the fields of psychiatry, clinical medicine, nutrition, and psychology.

Anorexia nervosa is defined as a state of self-inflicted starvation involving extensive disturbances in personality development that occurs chiefly, but not exclusively, in girls about the time of puberty. Part I of the book includes a discussion of changing approaches to anorexia nervosa during the 20th century; a review of 30 case studies; and a study of twin sisters, one normal and the other suffering from anorexia.

Part II discussed obesity in juveniles, its course and outcome; some aspects of the problem of regulating food intake in obesity; and psychotherapy and eating disorders.

THEORY AND PRACTICE OF SOCIAL PLANNING. Alfred J. Kahn. 348 pp. STUDIES IN SOCIAL POLICY AND PLANNING, Alfred J. Kahn. 326 pp. Russell Sage Foundation, New York, N.Y. 1969. $8.75 each.

The first of these companion volumes presents a model for planning that gives weight both to the struggles inherent in interest-group politics and community organization and the interplay of power between the politics and rationality of choice. The evolving theoretical conceptualizations concerning policy formulation provide a basis for blueprinting a dynamic planning process that may begin at any point, but will ultimately include consideration of problems and needs, definition of the planning task, formulation of the standing plan, programing, evaluation, monitoring, and feedback.

The author explains each of these components in detail. Though he emphasizes social welfare planning, he presents a synthesis of the development of planning theories in many areas, particularly economics. While he clearly specifies his own definition of critical concepts, he examines many different definitions and leaves the reader with the choice of using whatever frame of reference he prefers.

In providing perspective, the author briefly discusses the proposed strategy of "disjointed incrementalism" for dealing with the problem of the complexity of our society and the increasing interdependence of all components.

"Studies in Social Policy and Planning" provides case studies primarily from Federal programs that were developed in the '60s: antipoverty war, children's programs, income security, city planning, mental health, and social services delivery systems.

THE DEVIL HAS SLIPPERY SHOES: a biased biography of the Child Development Group of Mississippi. Polly Greenberg. The Macmillan Company. New York, N.Y. 1969. 704 pp. $14.95.

This is the story of the growth, development, and hard times of the first Head Start program in Mississippi as told by one of the initial organizers and member of the Mississippi project's central administrative staff. Taking the viewpoint that centers for preschool children in the poorest sections of Mississippi could do little for the children unless they grew out of the parents' own efforts, wishes, and pride, the staff focused its efforts on orienting people in isolated Negro communities to the possibilities of getting Federal help for doing something for their children, identifying natural community leaders, helping them to organize themselves and determine what they wanted for their children, and providing them with technical assistance when a problem arose.

Eighty-four preschool centers were in operation before the end of the first summer (1965)—22 of them with excellent programs, 19 of them "pretty terrible," and the rest of them with great possibilities, according to the author. She says: "The hardest thing in the world that summer was to withhold and watch and 'let' human beings develop." But the staff stuck to its convictions that "cracking the steel case of parental futility feelings comes before 'fertilizing' the child" and that *that* would have to mean not only parental involvement but parental control of all aspects of the project.

Much of the book is devoted to a description of the difficulties arising with "far-off Washington" when such a hands-off policy had to be combined with the requirement for accountability. It also tells of harrassment of the project from within the State.

CITIZEN BOARDS AT WORK: new challenges to effective action. Harleigh B. Trecker. Association Press, New York, N.Y. 1970. 288 pp. $7.50.

Addressed to the men and women who serve on boards of directors of community service agencies, this book examines the role of board members in meeting the social, educational, cultural, religious, health, and other needs of their areas. The author, a professor at the University of Connecticut School of Social Work, discusses the difference between policy-making and advisory boards; the relations between board members, the executive, and staff members of the agency; the concepts of representation and balance in building and organizing the board; the obligations of the board to the agency's constituency and to the community as a whole; the handling of conflict; and board member training as a continuing necessity.

The book lists six challenges that face members of today's boards: agency control; responsible participation; service organization, availability, and delivery; manpower recruitment, utilization, and salaries; finance and budget; and central planning. It points out the need for periodic evaluation of the work and objectives of all boards. An agenda for action presents ways of increasing an agency's abilities to meet the changing needs and demands of the times.

IN THE JOURNALS

Influences on self-image

A study of the relationship of children's self-esteem to some selected aspects of their lives is described by Robert R. Sears of Stanford University in the June 1970 issue of the quarterly, *Child Development*. ("Relation of Early Socialization Experiences to Self-Concepts and Gender Role in Middle Childhood.") The subjects were 159 sixth grade children—84 boys and 75 girls—whose mothers had been interviewed 7 years earlier regarding child-rearing practices and other family factors.

The author reports that the children's degree of self-satisfaction was measured by a Self-Concept Inventory through which they did a self-rating of their physical and mental abilities, their competence in various aspects of social relations, and a number of other qualities. The resulting scores were correlated by the author to information obtained in the earlier study about the family and the child—the degree of parental warmth, father or mother dominance, and the child's birth position—as well as with tests of the child's degree of femininity and degree of aggression.

The author reports that for both sexes a highly positive self-concept was associated with the presence of parental warmth—whether maternal or paternal—small family size, and being the oldest child in the family; that low father dominance was associated with highly positive self-concept in boys only; that warmth on the part of the father was associated with femininity in girls and masculinity in boys; and that femininity—as measured by occupational, recreational and other preferences—was associated in both sexes with poor self-concepts and feelings of aggression. He also reports an association between a highly positive self-concept and the child's IQ and his achievements in arithmetic and reading. The latter achievements, he says, are better predictors of a child's self-concept than is his IQ alone.

New methods

A child guidance program designed by questioning the assumptions of traditional treatment programs—that improvement in parent-child relationships can only be brought about by the resolution of inner conflicts or marital difficulties—is described in the July 1970 issue of *Social Work* by Norman Epstein, director of social work and group therapy at the Children's Psychiatric Center, Eatontown, N.J. ("Brief Group Therapy in a Child Guidance Clinic.")

On the theory that "one of the most difficult life tasks is that of parenthood," the clinic has evolved a system of brief therapy that is focused on educating parents and their first-born or only children to improve their competence in coping with one another, the author reports. In this program the parents are helped to alter their expectations and see alternative ways of dealing with the child in six weekly meetings with other parents in which the therapist—who may be a social worker, a psychiatrist, or a psychologist—takes an active role as clarifier, counselor, and teacher. At the same time in individual sessions, the child is helped to see how his behavior affects adults and to find more successful coping strategies. The agency also conducts short-term group sessions for adolescents.

The author reports that the agency is reevaluating the concept of long-term treatment, although it still carries out extended treatment for a few clients who do not seem to benefit from the shorter program. Staff members, he says, have moved away from "the compulsive seeing of pathology" to a greater acceptance of a wide range of behavior and to a more active involvement with community resources in behalf of the child. Since the inauguration of the brief therapy program, the waiting period for treatment at the agency has been reduced from over 6 months to 8 weeks.

Fantasy in adopted boys

Although the common fantasy of children—that the adults with whom they live are adoptive parents or stepparents—is no fantasy for adopted children, the tendency of an adopted child to romance about his natural parents poses no real identification problem for the child adopted in infancy, says Edward M. Schwartz in the July 1970 issue of *Child Welfare*. ("The Family Romance Fantasy in Children Adopted in Infancy.") The author bases his conclusions on a comparative analysis of the identification behavior of two groups of boys from upper-middle class families in Ann Arbor, Mich., one group composed of 25 boys placed in adoptive homes before the age of 6 months and the other a matched control group of 25 boys living with both natural parents.

Pointing out that he finds no indication that prolongation of the "family romance" is a universal characteristic of children adopted in infancy, the author notes that the adopted boys in his study show a positive interest in and acceptance of their adoptive parents as role models on a level similar to that of their nonadopted peers. The boys were curious about their biological parents in regard to their physical appearance, whereabouts, or reasons for not keeping their sons, the author says. However, only two boys perceived their biological parents in fantasy as "particularly special in a positive sense."

The author warns against concluding from his observations that fantasy does not affect children adopted at a relatively older age or brought up in "one or more foster homes."

Dr. Schwartz is an instructor in psychology at the University of Michigan Medical School.

PKU screening

The interrelationships of physicians in populous areas is "a most influential factor" in supporting or hindering voluntary programs for the mass screening of newborns for phenylketonuria, maintain three physicians from the Univer-

sity of Washington School of Medicine in an article in the June 15, 1970, issue of *JAMA*. ("Some Factors Influencing the Development of a Voluntary PKU Screening Program," by Vanja A. Holm, M.D., William M. Deering, M.D., and Rhesa L. Penn, M.D.)

Reporting on a statewide voluntary program for screening newborns, they cite a large Washington county in which a low incidence of testing was directly related to a decision by a group of physicians not to endorse PKU screening, although the procedure was accepted medical practice in other communities in the State and was supported by the Washington State Medical Association and the State Department of Health.

On the basis of questionnaires returned from nearly all hospitals with obstetrical services, the authors report that the percentage of newborns tested for PKU in the State increased from 45 to 69 percent between the years 1965 and 1967. They found variations in screening adequacy among hospitals of all sizes, ranging from less than 10 percent of newborns screened to over 80 percent. A greater proportion of the hospitals with over 700 births a year reported testing at least 80 percent of the newborns than hospitals with fewer births. The authors also found that hospitals do not automatically maintain screening programs at a high level once it is achieved; that the attitude of the hospital's medical staff toward screening procedures affects the level of screening reached; and that a mandatory testing policy within a hospital does not always bring a high level of achievement.

Pointing to a need for a coordination of various types of screening programs for newborns, the authors suggest that consideration will need to be given in the future to the as-yet-unresolved issue of voluntary or legislated screening.

READERS' EXCHANGE

GROSS: Evidence of the possible

Norman Gross in his article, "Reaching for the Dream—An Experiment in Two-Way Busing" (CHILDREN, July–August 1970), reports what I believe many of us who have worked with the issues of busing school children to achieve better racial integration have noted again and again—that black children and white children from different backgrounds and varying circumstances can come together and learn about one another, and learn more effectively as individuals. It is not impossible in this country to find significant numbers of white people who are quite willing to have their children transported from an immediately nearby school to a distant one that offers special advantages.

I have come to believe that the whole issue of busing is a false one. For years all through the South and Appalachia I saw poor white children bused miles and miles, and no one was unhappy about it. Furthermore, I saw white children bused in order to avoid integration with black students. That also is the case in many northern cities and towns. The word "busing" has aroused a great deal of fear and anxiety in parents, but on the basis of my work with many anxious parents, I have learned that the fear is not so much of the bus, or the travel, but really has to do with two words that I used to hear over and over again in Mississippi and Louisiana, and now hear frequently in the North, "race-mixing."

Because some people are afraid of getting to know their fellowman, there's no reason for those many who are quite eager to come to know others to become pessimistic. The experiment that Mr. Gross describes may not be universally applicable; but there *are* many white people and black people all over this country who are willing to initiate similar experiments and who deserve encouragement and support.

What children learn in such experiments is not the kind of knowledge that can be easily quantified. Learning and education have to do with ethical values and with the heart and spirit as well as the brain. The kind of experiment that Mr. Gross describes offers some hope that this country has in it more than a collection of self-aggrandizing "groups," utterly unwilling to reach out and respond to neighbors, fellow citizens, fellow human beings.

As a clinician who has worked with so-called lower middle class white families, many of them outspokenly racist, I can say that even in the most fearful and suspicious people, there are elements of real concern and compassion. We often underestimate people because we are unwilling to educate both them and ourselves to what might be possible, given not only understanding, but real determination and courage. As a child psychiatrist I know what children are capable of—whatever their background or race. I am a little less hopeful of social or political institutions.

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GARRETT: Foster parents' rights

I read with much interest the compilation by Beatrice L. Garrett on "The Rights of Foster Parents" in the May–June 1970 issue of CHILDREN. I would like to suggest expansion of item 10 which deals with the opportunity to be listened to regarding agency practices.

If a foster parent is to have a "right" concerning practice, I feel that the same parent should have a right regarding *policy*, which establishes the grounds for program formulation and practices. Foster parents should not only "be lis-

tened to" as staff members, but should also have an active decision-making role shared with others in agency policies. I believe that foster parents would then have a clearer identification as to their roles in relation to natural parents, children, the agency, and the community and less of a problem in deciding whether they are "fish or fowl."

Paul A. Guerard
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The right to learn

I was gratified to see Miss Garrett's suggestions for implementation of a people-to-people approach to foster parents.

Remnants of a depersonalizing agency-to-people method still maintain, and Miss Garrett's recommendation definitely turns away from this outmoded system.

I would like to suggest one particular "right" for emphasis: professional education. Although training and staff development is implied in Miss Garrett's list of rights (numbers 1, 2, 3, and 6) I would still urge that specific mention be made of education of the foster parent even above and beyond supportive and informative involvement in the agency's program.

Foster parents have responsibility for a tremendously significant contribution to society. They are, as Miss Garret affirms, entitled to "opportunity to learn and grow" (right number 9). I submit that this should be highlighted by stating that foster parents have the right to appropriate education or training for their roles, or both.

Sister Mary Patrick
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BOYLE: Service and social change

I am intrigued by the article in the July–August issue of CHILDREN, "A Learning Experience in Helping Parents Get What They Want," by John Boyle and the "Epilogue" by Dorothy Randolph. This material raises many issues, all of which are tempting to comment on. Mr. Boyle himself in his summary raises very pertinent questions.

As a social work educator I find it difficult to pass up the opportunity to talk about the rich learning experience available to Mr. Boyle in his field work. I regard his material, along with the "Epilogue," as important documentation in support of a unified view of offering people in trouble direct services and at the same time seeking to affect or modify the social policies that bear upon them. We are in an era in which social planners and practitioners too often tend to view each other across a gulf and with mutual suspicion.

In struggling with the group process, Mr. Boyle found that the key needed to elicit significant participation from the group members was involvement in planning for a concrete result. He was somewhat taken aback by the amount of work that he himself had to do in the face of the slow and laborious development of action groups. Nevertheless, one could point out that the parents in articulating their children's needs and in playing some part in bringing about the Saturday program and the eventual school, were functioning most appropriately *as parents.*

I wish this point had come through a little more clearly—that the parenting role is not separate nor apart from the social change role in this kind of situation. Mr. Boyle was able to provide direct service while simultaneously functioning as an agent of social change.

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BRANHAM: Implications for unwed parents

Ethel Branham's excellent article, "One-Parent Adoptions," (CHILDREN, May-June 1970) has important implications for work with unwed parents. Knowing about the apparently successful efforts of the Los Angeles County Department of Adoptions in finding secure adoptive homes for children in single-parent families ought to reassure not only child placement workers, but also workers who are involved in parents' choices, of the possibility of finding adoptive homes for "hard-to-place" children. In addition, the program's effectiveness should have meaning for unwed parents who are considering surrendering a child to an agency's care.

Ideally any unwed mother should be able to surrender her child if she is psychologically ready to do so. However, some mature unwed mothers who are aware of the many "hard-to-place" children needing placement may only be willing to surrender their child to an agency if the agency assures them that the child will be adopted. Without definite adoptive possibilities, the worker or the adoption agency, or both, may consider it unconscionable to accept responsibility for a child from an unwed mother if that mother is psychologically mature and motherly by nature, and so might have more to offer the child than does the agency. (Needless to say, many adolescents and others too would not fall into this classification.)

A one-parent adoption program, even though a second best choice for a child, offers the agency and the mother a real alternative to the uncertainty of waiting for a two-parent home. For a mother who is confronted with the trauma of surrender along with other emotional problems, the certainty that her child will be adopted is a healing and supportive force.

An unwed mother, and others, may well ask: what can a single adoptive parent offer a child that an unwed mother could not offer by keeping her child herself? In the one-parent placements described by Mrs. Branham, the adoptive parents held such positive attributes for parenthood as healthy motivation for wanting a child, joyfulness about child-rearing, and ability to plan adequately and realistically for the child. Such attributes may be missing in an unmarried mother who keeps her child only because there is no alternative.

Other positives provided in the program described derive from the criteria established for selecting single-parent adoptive homes, notably emotional maturity on the part of the applicant and the availability of suitable substitutes for sexual identification. The Los Angeles County Department of Adoptions has provided an inspiring example of flexibility, determination, innovation, and creativity in meeting the needs of children who otherwise would, in a sense, be homeless.

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U.S. Government Publications

Publications for which prices are quoted are for sale by the Superintendent of Documents, U.S. Government Printing Office, Washington, D.C. 20402. Orders should be accompanied by payment. Twenty-five percent discount on quantities of 100 or more.

VOLUNTARY ACTION TO STOP RUBELLA! HEW, PHS, Center for Disease Control, Atlanta, Ga. 30333. 1970, 12 pp. Single copies free from CDC.

Describes ways in which voluntary action groups can help in programs to stop rubella.

MENTAL HEALTH AND THE DEAF: approaches and prospects. A report of the National Conference on Mental Health Services for Deaf People, sponsored by the New York State Psychiatric Institute, Houston, Tex.—February 14–17, 1968. Kenneth Z. Altshuler, M.D., and John D. Rainer, M.D., HEW, SRS, Rehabilitation Services Administration. 1969. 162 pp. Single copies free from the Institute, 722 West 168th Street, Houston, Tex. 10032.

Contains the keynote address and resource papers prepared for the conference and summaries of the discussions and the proposals of discussion groups on education, psychology, rehabilitation, religion, and social work in relation to work with deaf children and adults.

CHILDREN OF DIVORCED COUPLES: United States, selected years. Vital and Health Statistics. HEW, PHS, National Center for Health Statistics. PHS Publication No. 1000, Series 21, No. 18. 1970. 40 pp. 50 cents.

Through the use of tables and charts, this booklet reports on divorces involving children under 18 years of age in the United States. It points out that the number of children involved in divorces has increased sixfold since 1922 and has doubled since 1950.

RESEARCH RELATING TO CHILDREN: bulletin No. 25 (April–December 1969). HEW, OCD, Children's Bureau, Clearinghouse for Research in Child Life. 1970. 131 pp. $1.25.

Contains brief descriptions of current or recently completed research studies reported to the Children's Bureau between April and December 1969, dealing with child growth and development, personality and adjustment, special groups of children, the child in the family, socioeconomic, cultural, and educational factors in development, and social, educational, and health services.

MENTAL HEALTH DIRECTORY 1970. HEW, National Institute of Mental Health, National Clearinghouse for Mental Health Information. Publication No. 1005. 1970. 455 pp. $4.

Lists more than 3,000 facilities in the United States, by county, that provide mental health services; gives type of service, address, and areas where the services are administered.

CHILD CARE SERVICES PROVIDED BY HOSPITALS. Department of Labor, Wage and Labor Standards Administration. Women's Bureau Bulletin 295. 1970. 34 pp. 25 cents.

Gives results of a survey of 3,000 hospitals having 100 or more beds to learn how many have child care centers for their employees. A total of 98 hospital child care centers were reported, 79 of which are in the hospital or on the hospital grounds.

HEW refers to Department of Health, Education, and Welfare; OCD, to Office of Child Development; PHS, to Public Health Service; SRS, to Social and Rehabilitation Service.

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